REQUEST FOR QUALIFICATIONS (RFQ)

Acquisition Title:	**RSN Procurement** **RFQ #0534-187**
Summary of Expected Results:	As a result of this RFQ, the Department of Health and Social Services will select qualified Regional Support Networks (RSN) to provide community mental health programs that help people experiencing mental illness to retain a respected and productive position in the community.
Response Due Date:	This solicitation is open through December 1, 2005. All responses, whether mailed or hand delivered, must be received at the following address by 3:00 p.m. local time December 1, 2005. **Faxed or electronically mailed responses <u>will not</u> be accepted.**
Submit Response to:	Andrew Kramer, RFQ Coordinator Department of Social and Health Services Administrative Services Division, Central Contract Services Mailing Address: P.O. BOX 45811 Olympia, Washington 98504-5811 Physical Address: 4500 10th Avenue SE Lacey, Washington 98503 Telephone: (360) 664-6073 FAX: (360) 664-6184 Email: rsnprocurement@dshs.wa.gov Reference: RFQ – #0534-187
RSN Eligibility:	This solicitation is open only to RSNs existing on the date and time for the submission of a response.
Special Notes:	RSNs are responsible for accessing the RFQ document through the DSHS procurement web site http://www1.dshs.wa.gov/msa/ccs/ and are responsible for checking the same site for any future notifications, amendments, etc. All RSNs who wish to participate must able to communicate with the RFQ Coordinator via e-mail.

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1. INTRODUCTION

1.1. **Purpose of Request for Qualifications**

The State of Washington (Washington), Department of Social & Health Services (DSHS), is initiating this Request for Qualifications (RFQ) in accordance with RCW 71.24.300. RCW 71.24 was enacted to provide community mental health (MH) programs that help people experiencing mental illness to retain a respected and productive position in the community. RCW 71.24.300 requires the issuance of this RFQ to qualify existing Regional Support Networks (RSNs) to operate Prepaid Inpatient Health Plans (PIHP) for Medicaid-enrollees and to arrange for or provide State-funded services for persons who meet State eligibility requirements.

DSHS is initiating this RFQ to solicit responses from RSNs to operate managed care programs that oversee services for Title XIX enrollees and persons eligible for State funded services that enhance DSHS' vision and guidelines, and specifically:

1.1.1. Promote the involvement of persons with mental illness, their family members, and advocates in designing and implementing MH services.

1.1.2. Reduce unnecessary hospitalization and incarceration.

1.1.3. Improve the quality of services available and promote resilience, rehabilitation, recovery and reintegration and employment of persons with mental illness.

1.1.4. Increase access to evidence-based, research-based, consensus-based, and promising practices.

1.1.5. Improve collaboration with chemical dependency and criminal justice agencies.

1.1.6. Improve the accountability of the MH system to ensure that funds appropriated by the Legislature are expended for the purpose intended.

The contract resulting from this RFQ will be administered by the DSHS/MHD.

1.2. **Background**

The Washington State Legislature passed the County-Based Mental Health Services Act, Laws of 1989, Ch. 205, to create a single point of local responsibility for MH services. This legislation created county-based RSNs to design and administer MH delivery systems to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering MH services in 1993 under a 1915(b) waiver in 1993, for outpatient MH services. The capitated, managed MH system gives the

RSN the ability to design an integrated system of MH care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. Establishing capitated managed care gave the State the ability to control the rate of financial growth and improve MH service outcomes. The MH services covered under the waiver were the full range of community MH rehabilitation services offered under the Medicaid State Plan through a fee-for-service (FFS) reimbursement system. The MH services stress ongoing community support to provide the enrollee with tailored services that are responsive to their individualized needs.

In 1997, an amendment to the existing waiver was approved, which incorporated community psychiatric inpatient services for Medicaid eligible adults, older persons, and children into the capitated contracts with the RSNs. An essential component of the waiver amendment was to provide the RSNs the first opportunity to demonstrate qualifications and enter into an integrated full-risk capitated MH services contract with MHD. MHD took this approach due to the existing unique structure of MH and human service delivery systems administered by counties and the RSNs under State law. Pursuant to the Community Mental Health Services Act (RCW 71.24), the RSNs administer all community MH services funded by the State. Under the Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for evaluating and detaining people who are in need of involuntary treatment.

In 2005, the Washington State Legislature mandated the issuance of this RFQ to qualify a minimum of 8 and a maximum of 14 RSNs (RCW 71.24.360). The intent of this RFQ is to select qualified RSNs that improve the quality and accountability of the MH system and to promote the vision of recovery for people with mental illness.

DSHS/MHD has the vision that all people in the State of Washington who experience mental health challenges will lead happy productive and fulfilling lives, free of stigma, in a safe and least restrictive environment. The mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and as a condition from which people can and do recover.

In this vision, mental illness emerges from the shadows of stigma and ignorance to a place of greater public understanding. This understanding transcends cultural difference because it is informed by an array of diverse cultural practices. Mental health services are transformed as consumer experiences systematically and continually guide the system. The following guidelines will drive changes to the mental health system:

1.2.1. Mental Health services must be based on the principles of wellness and recovery, and place consumers and families at the center of all State efforts of system change and improvements.

1.2.2. The stigma of mental illness will be reduced and recovery will be possible for all consumers.

1.2.3. Evidence-based practices will be implemented, and the wellness/recovery model will be integrated into culturally-competent, individualized service plans.

1.2.4. All policies and programs will ensure that continuity, alignment, and quality of care occur.

1.3. **Minimum Qualifications for Submission of a Response**

The bidder must be an existing RSN operating in Washington on the date and time of submission. RSNs who do not meet these minimum qualifications shall be deemed non-responsive and will not receive further consideration.

1.4. **Commitment of Funds**

The Secretary of DSHS or her delegate is the only individual who may legally commit DSHS to the expenditure of funds for a contract resulting from this RFQ. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

1.5. **Americans With Disabilities Act**

DSHS complies with the Americans with Disabilities Act (ADA). RSNs may contact the RFQ Coordinator to receive this RFQ in an alternate format.

1.6. **Nondiscrimination**

No individual shall be excluded from participation in, denied the benefits of, subjected to discrimination under, or denied employment in the administration of or in connection with any program provided by this contract because of race, color, creed, marital status, religion, sex, sexual orientation, national origin, Vietnam Era, or disabled veterans status, age, the presence of any sensory, mental, or physical disability, or political affiliation or belief. The prohibition against discrimination in employment shall not apply if the particular disability prevents the individual from performing the essential functions of his/her position, with reasonable accommodations.

1.7. **Definitions**

The following terms which appear in this RFQ have the meaning that is defined below:

1.7.1. "Action" means, in the case of a PIHP, the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the DSHS; or the failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b).

1.7.2. “Apparently Successful RSN (ASR)” means an RSN whose response is judged to meet the qualifications describe in this RFQ. The RSN is considered an "apparently" successful RSN until a contract is finalized and executed.

1.7.3. “Appeal” means a request for review of an action as “action” is defined above.

1.7.4. “Available Resources” means funds appropriated for the purpose of providing community MH programs, federal funds, except those provided according to Title XIX of the Social Security Act, and State funds appropriated under chapter 71.24 RCW or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other MH services. This does not include funds appropriated for the purpose of operating and administering the State psychiatric hospitals, except as negotiated according to RCW 71.24.300(1)(d).

1.7.5. “Care Manager” means a staff person of the RSN that manages access to referrals, care authorization, care coordination, utilization review, and resource management.

1.7.6. “CFR” means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor, amended, or replacement regulation.

1.7.7. “Child” means a person under the age of 18 years.

1.7.8. “Chronically Mentally Ill Adult” means an adult who has a mental disorder and meets at least one of the following criteria: (a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or (b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months’ duration within the preceding year; or (c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months.

1.7.9. “Community Mental Health Agency (CMHA)” means community MH centers that are subcontracted by the PIHP and licensed to provide MH services covered under this RFQ and exhibits.

1.7.10. “Community Support Services” means services authorized, planned, and coordinated through resource management services, including, at a minimum, assessment, diagnosis, emergency crisis intervention available 24 hours, 7 days a week, prescreening determinations for mentally ill persons being considered for placement in Skilled Nursing Facilities as required by federal law, screening for patients being considered for admission to residential services, diagnosis, and treatment for acutely mentally ill and severely emotionally disturbed children discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other

nonresidential services under RCW 71.05, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by regional support networks.

1.7.11. "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.

1.7.12. "Consumer" means a person who has applied for, is eligible for, or who has received MH services. For a child, under the age of 13 or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

1.7.13. "Contractor" means an organization whose response has been selected by DSHS' evaluation process and is awarded a formal written contract to provide the services that are the subject of this RFQ.

1.7.14. "Designated Mental Health Professional" means a mental health professional designated by the county or other authority authorized in rule to perform duties specified in RCW 71.24, RCW 71.34 and RCW 71.05.

1.7.15. "DSHS" means the Department of Social and Health Services.

1.7.16. "Emerging Best Practice" or "Promising Practice" means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.

1.7.17. "Enrollee" means a Medicaid recipient.

1.7.18. "EPSDT" means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act, as amended.

1.7.19. "Evidence-based" means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.

1.7.20. "Fair Hearing" means an "adjudicative proceeding" as defined in RCW 34.05.010(1).

1.7.21. "Family" means those the consumer defines as family or those appointed/assigned (e.g., parents, foster parents, guardians, siblings, caregivers, and significant others).

1.7.22. “Grievance System” means the overall system that includes processes for grievance and appeals handled at the RSN level and access to the State fair hearing process.

1.7.23. “In-Residence Census” (IRC) means the in-residence census of all voluntary and involuntary consumers, regardless of where in the State hospital they are housed. Consumers who are committed to the State hospital under RCW 10.77 are not included in the IRC. Consumers who are committed by municipal or district court judges after failed competency restoration are considered committed under RCW 10.77 until a petition for 90 day civil commitment under RCW 71.05 has been filed in court.

1.7.24. “Large Rural Area” means areas with a population density of less than 20 people per square miles.

1.7.25. “Medical Necessity” or “Medically Necessary” means a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all. Additionally, the individual must be determined to have a mental illness covered by Washington for public MH services. The individual’s impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual’s unmet need.

1.7.26. “Mental Health Care Provider (MHCP)” means the individual with primary responsibility for implementing an individualized service plan for MH rehabilitation services.

1.7.27. “MHD” means the Mental Health Division is the operating division of DSHS under the Health and Recovery Services Administration (HRSA) responsible for oversight of MH services provided through this RFQ.

1.7.28. “Mental Health Professional (MHP)” means:

1.7.28.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters RCW71.05 and RCW71.34.

1.7.28.2. A person with master's degree or further advance degree in counseling or one of the social sciences from accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of mental health professionals.

1.7.28.3. A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986.

1.7.28.4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the Regional Support Network and granted by the Mental Health Division prior to July 2001.

1.7.28.5. A person who has been granted a time limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.

1.7.29. "Response" means all material prepared and assembled by an RSN, and which the RSN submits in response to this RFQ.

1.7.30. "Protest" means an objection by the RSN, in writing, protesting the results of this RFQ and which complies with all requirements of this RFQ.

1.7.31. "RFQ Coordinator" means the person named in this RFQ as the RFQ Coordinator, or the RFQ Coordinator's designee within Central Contract Services and the sole point of contact within DSHS regarding this RFQ for RSNs and other interested parties.

1.7.32. "RFQ" means the Request for Qualifications, i.e., this RFQ document. The RFQ is used as a solicitation document in this procurement, as well as all amendments and modifications thereto. The RFQ is a documented, formal procurement process providing RSNs an equal and open opportunity to respond to the requirements Stated in the RFQ.

1.7.33. "RCW" means Revised Code of Washington. All references to RCW chapters or sections shall include any successor, amended, or replacement statute.

1.7.34. "Recovery" means the process in which people are able to live, work, learn, and participate fully in their communities.

1.7.35. "Regional Support Network (RSN)" means a county authority or group of county authorities or other entity recognized by the Secretary in contract in a defined region.

1.7.36. “Research-based” means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

1.7.37. “Residential Services” means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for acutely mentally ill persons, chronically mentally ill adults, severely emotionally disturbed children, or seriously disturbed adults determined by the regional support network to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis, respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service mentally ill persons in Skilled Nursing Facilities boarding homes and adult family homes. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children’s long-term residential facilities existing prior to January 1, 1991.

1.7.38. “Resilience” means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.

1.7.39. “Routine Services” means non-emergent and non-urgent services are offered within 14 calendar days to individuals authorized to receive services as defined in the access to care standards. Routine services are intended to stabilize, sustain, and facilitate consumer recovery within his or her living situation.

1.7.40. “Rural” means areas with a population density of at least 20 and less than 500 people per square mile.

1.7.41. “Secretary” means the Secretary of the Department of Social and Health Services.

1.7.42. “Service Area” means the geographic area of the RSN.

1.7.43. “Subcontract” means a separate contract between the RSN and an individual or entity (“Subcontractor”) to perform all or a portion of the duties and obligations which the RSN is obligated to perform pursuant to this Agreement.

1.7.44. “Tribal Authority,” for the purposes of this RFQ and RCW 71.24.300 only, means: The federally recognized Indian tribes and the major Indian organizations recognized by the secretary insofar as these organizational do not have a financial relationship with any regional support network that would present a conflict of interest.

1.7.45. “Urban” means areas that have a population density of at least 500 people square mile.

1.7.46. “Urgent Service” means a service to be provided to persons approaching a MH crisis. If services are not received within 24 hours of the request, the person’s situation is likely to deteriorate to the point that emergent care is necessary.

1.7.47. “WAC” means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor, amended, or replacement regulation.

1.7.48. “Waiver” means a document by which DSHS, MHD, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients. Section 1915(b) of the SSA, authorizes the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program.

2. RFQ ADMINISTRATIVE INFORMATION AND REQUIREMENTS

2.1. **Procurement Contact Information**

Upon release of this RFQ, all communications concerning this RFQ must be directed to the RFQ Coordinator listed on the cover page of this RFQ. The RFQ Coordinator is the sole point of contact for this procurement.

Contact the RFQ Coordinator in writing by email, fax, or mail if you have any questions or concerns related to any portion of this RFQ. Any other communication will be considered unofficial and non-binding on DSHS. RSNs are to rely on written Statements issued by the RFQ Coordinator. Communication directed to parties other than the RFQ Coordinator will have no legal bearing on this RFQ and may result in disqualification of the RSN.

Please contact the RFQ Coordinator if you have any questions or concerns.

2.2. **Procurement Schedule**

The Procurement Schedule outlines the tentative schedule for important dates and times. DSHS reserves the right to revise this schedule at any time and will post any amendment to the schedule on the DSHS Procurement website.

Procurement Schedule – all times are Pacific Time

Item	Action	Date
1.	Issue RFQ	September 30, 2005
3.	Pre-Response Conference (optional to RSNs)	October 19, 2005
2.	Last Date for Accepting RSN Written Questions by 3:00 PM	October 26, 2005
4.	Response Submission Due by 3:00 PM	December 1, 2005
5.	Response Evaluation Begins	December 12, 2005
6.	Notify Apparently Successful RSNs	January 5, 2006
7.	Notify Unsuccessful RSNs	January 5, 2006
8.	RSN's Request for Debriefing Due by 3:00 PM	January 9, 2006
9.	Hold Debriefing Conferences (optional to RSNs)	January 10-12, 2006
10.	RSN's Protest(s) Due	January 17, 2006
11.	Signed Contracts Due	August 15, 2006
12.	Contract Execution	September 1, 2006
13.	Begin work	September 1, 2006

2.3. **Pre-Response Conference**

A conference to address requirements will be held at the time and location indicated below. Prospective RSNs are encouraged to attend; however, attendance is not mandatory. If changes are required as a result of the conference, an amendment will be issued.

Date:	October 19, 2005
Time:	9:00 a.m. to 12:00 p.m.
Location:	Lookout Conference Room Office Building 2 Olympia, Washington

Directions will be provided upon request.

Assistance for disabled, blind, or hearing-impaired persons who wish to attend is available with pre-arrangement with DSHS. Contact the RFQ Coordinator identified on the face page of this document.

Specific questions concerning this RFQ must be submitted to the RFQ Coordinator in writing. DSHS will attempt to give preliminary answers at the Pre-Response Conference to any questions received by 5:00pm October 14, 2005. Additional questions will be entertained at the conference, but responses may be deferred and provided at a later date.

The answer to any question that is given orally at the conference is to be considered as tentative. After the conference the official, written answers to questions will be published. This will assure accurate, consistent responses to all RSNs. All questions and DSHS answers will be posted to the DSHS Procurement Website. DSHS shall be bound only to written answers to questions. Any oral responses given at the Pre-Response Conference shall be considered unofficial.

No questions will be accepted by DSHS after 3:00 PM, October 26, 2005.

2.4. **Acceptance of RFQ Terms**

A Response submitted in response to this RFQ shall be considered a binding offer. Acknowledgement of this condition shall be indicated by signature of an officer of the RSN legally authorized to execute contractual obligations by submitting with the Response a signed **RSN INFORMATION, CERTIFICATES AND ASSURANCES FORM** attached hereto as **EXHIBIT A.**

2.5. **Contract**

The Apparently Successful RSNs will be expected to sign contracts with DSHS that are modeled after the sample PIHP and State Funded contracts included as EXHIBIT B and EXHIBIT C. The terms of the contract are not subject to negotiation.

The period of performance of any contracts resulting from this RFQ are tentatively scheduled to begin September 1, 2006. Amendments extending the period of performance, if any, shall be at the sole discretion of DSHS. DSHS reserves the right to extend the contracts for up to 2 years.

Specific restrictions apply to contracting with current or former State employees pursuant to chapter 42.52 of the Revised Code of Washington. RSNs should familiarize themselves with the requirements prior to submitting a Response.

2.6. **Written Representations**

Responses must be based on the material contained in this RFQ, any related amendment(s), and any questions and answers directed through the RFQ Coordinator.

2.7. **Questions and Answers**

RSNs should fax, e-mail or mail written questions to the RFQ Coordinator. Early submission of questions is encouraged. Questions will be accepted until the date set forth in the Procurement Schedule. Questions and Answers will be posted on the DSHS Procurement website. No questions will be accepted after the date Stated in the procurement schedule. DSHS will not accept questions from parties not qualified to bid on this RFQ.

2.8. **Exhibits**

Exhibits to this RFQ are:

EXHIBIT A - RSN INFORMATION, CERTIFICATIONS AND ASSURANCES FORM
EXHIBIT B – MODEL PIHP CONTRACT
EXHIBIT C– MODEL STATE FUNDED CONTRACT
EXHIBIT D – CHECKLIST FOR RESPONSIVENESS

2.9. **Administrative Requirements**

2.9.1. **Costs to Propose**

DSHS is not liable for any costs incurred by the RSN in preparation of a response submitted in response to this RFQ, in conduct of a presentation, or any other activities related to responding to this RFQ.

2.9.2. **Signatures**

The Letter of Submittal and the Certifications and Assurances form must be signed and dated by a person authorized to legally bind the RSN to a contractual relationship.

2.9.3. **Revisions to the RFQ**

DSHS reserves the right, at any time before execution of contracts, to revise all or a portion of this RFQ and/or to issue amendment(s) to the RFQ. If there is any conflict between amendments or between an amendment and the RFQ, whichever document was issued last in time shall be controlling. For this purpose, the specific questions and answers from the RSNs and/or the pre-response conference and other pertinent information shall be provided as an amendment to the RFQ.

Amendments will be posted on the DSHS Procurements web site, if applicable. It is incumbent on the RSN to visit the DSHS Procurement web site http://www1.dshs.wa.gov/msa/ccs/ in order to receive any and all notifications and amendments.

DSHS reserves the right to cancel or to reissue the RFQ in whole or in part, prior to execution of contracts.

2.9.4. **Response Rejection**

DSHS also reserves the right at its sole discretion to reject any and all response received without penalty and not to issue contracts as a result of this RFQ.

2.9.5. **Responsiveness**

A **CHECKLIST FOR RESPONSIVENESS** is attached as **EXHIBIT D** to assist the RSN in preparing the response. Responses that do not address all areas requested by this RFQ may be deemed non-responsive and may not be considered for possible contracts resulting from this RFQ. All responses, as well as any reference material presented, must be written in English.

All responses will be reviewed by the RFQ Coordinator to determine compliance with the requirements and instructions specified in this RFQ. The RSN is specifically notified that failure to comply with any part of the RFQ may result in rejection of the response and therefore deem the response non-responsive.

DSHS reserves the right, at its sole discretion, to waive minor administrative irregularities and or informalities.

2.10. **Obligation to Contract**

DSHS and Washington are not obligated to contract for the services specified in this RFQ. DSHS reserves the right to retract this RFQ in whole, or in part, at any time without penalty.

2.11. **Response Preparation Requirements**

2.11.1. **Answers to All Subsections Required**

An answer should be provided for every item indicated with an MR or MSR. Failure to provide an adequate answer to any such subsection that requests information or solicits an answer may cause the response to be deemed non-responsive and be disqualified from the evaluation process.

2.11.2. **Restatement of RFQ Requirements**

Responses must provide answers to the RFQ requirements by reiterating the number and text of the requirement in sequence and providing answers immediately following each requirement. To assist in the evaluation process, each answer should start on the same page as the requirement and should be followed with a page break.

2.12. **Response Submission Format**

Submit one set of binders marked "Original" with the RSN's name and ~~seven~~ six copies of your response. In addition, include one electronic copy in Microsoft Word 2000 file format or Microsoft Excel 2000 file format, if appropriate, on a portable media or electronic readable media (Compact Disc (CD-ROM), with a label on the CD identifying your name and RFQ reference number as shown on the cover page of this RFQ. Clearly mark your response to the attention of the RFQ Coordinator and with the RFQ reference number as shown on the cover page to this RFQ. In the event of a discrepancy between the response submitted on disk and the hard copy, the hard copy will prevail.

The paper copy of the response must be on standard eight and one-half by eleven inch (8 ½" x 11") white paper. A font size not less than 12 point must be used. Responses must be submitted in three-ring binders with tabs separating the major sections of the response identified in section 3 of this RFQ. Identify each copy of your response by including the RFQ reference number as shown on the cover page of this RFQ; the title of this RFQ, and your name on the front cover.

Responses to each question or request for information in the response must appear in the order presented in this RFQ in the response Contents section, with the same headings used herein. This will not only be helpful to the evaluators of the response, but should assist the RSN in preparing the response.

2.13. **Delivery of Responses**

RSNs mailing responses should allow normal mail delivery time to ensure timely receipt of their responses by the RFQ Coordinator. RSNs assume the risk for the method of delivery chosen. DSHS assumes no responsibility for delays caused by any delivery service. Responses may not be transmitted using facsimile transmission. The response, whether

mailed or hand delivered, must arrive at DSHS, at the address, date, and time indicated on the cover page to this RFQ.

Responses submitted by fax will not be accepted and will be considered non-responsive. DSHS reserves the right to disqualify any response and withdraw it from consideration if it is received after the response submission due date and time. All responses and any accompanying documentation become the property of DSHS and will not be returned.

2.14. **Acceptance Period**

The RSN must certify in writing that all RSN response terms, will remain in effect for a minimum of three-hundred sixty-five (365) days after the response due date and continue through the term of the contracts. **EXHIBIT A – RSN INFORMATION, CERTIFICATIONS AND ASSURANCES FORM** is provided for certification purposes and must be completed and filed as a part of the RSN's Financial/Contractual Response. Responses providing less than the required number of days for acceptance by DSHS will be considered non-responsive and will be rejected.

2.15. **Errors and Omissions in Responses**

DSHS will not be liable for any errors or omissions in the RSN's response. RSNs will not be allowed to alter or supplement their response documents after the response due date unless the alterations are the result of a request by DSHS as noted below.

DSHS reserves the right to make corrections or amendments to the response due to errors identified by DSHS or the RSN. This type of amendment will only be allowed for such errors as typing, transposition, omission, or any other obvious error. Any changes will be date and time stamped and attached to responses. All changes must be coordinated in writing with, authorized by, and made by the RFQ Coordinator. RSNs are liable for all errors or omissions contained in their responses.

2.16. **Withdrawal of Responses**

RSNs may withdraw a response that has been submitted at any time up to the response due date and time. To accomplish this, a written request signed by an authorized representative of the RSN must be submitted to the RFQ Coordinator. After withdrawing a previously submitted response, the RSN may submit another response at any time up to the closing date and time.

2.17. **Proprietary Information/Public Disclosure**

Materials submitted in response to this RFQ shall become the property of DSHS.

In order to protect the integrity of the contracting process which is a vital State interest, all responses shall remain confidential and will not be disclosed until after award and signing of the contracts. It is DSHS' duty to conduct the State's business in such a way as to protect the

public. In order to so protect, DSHS will not disclose bids before contract are signed. Thereafter, the responses shall be deemed public records as defined in RCW 42.17.250 to .340, "Public Records."

Any information in the response that the RSN desires to claim as proprietary and exempt from disclosure under the provisions of RCW 42.17.250 to .340 must be clearly designated. Each page claimed to be exempt from disclosure must be clearly identified by the words "Proprietary Data" printed on the lower right hand corner of the page. Each page so identified must include a Statement of the basis for such claim of exemption or the particular exception from disclosure upon which the RSN is making the claim.

DSHS will consider a RSN's request for exemption from disclosure; however, DSHS will make a decision predicated upon applicable laws. The RSN must be reasonable in designating information as confidential. If any information is marked as proprietary in the response, such information will not be made available until the affected RSN has been given an opportunity to seek a court injunction against the requested disclosure.

Marking the entire response exempt from disclosure will not be honored and will, in fact, be grounds for disqualification from the evaluation process.

DSHS' sole responsibility shall be limited to maintaining the above data in a secure area and to notify RSN of any request(s) for disclosure within a period of five (5) years from date of award. Failure to so label such materials or failure to provide a timely response after notice of request for public disclosure has been given shall be deemed a waiver by the RSN of any claim that such materials are, in fact, so exempt. Confidentiality is available only to the limited extent allowed in State law. DSHS may choose to disclose despite information being marked as confidential.

A charge will be made for copying and shipping, as outlined in RCW 42.17.300. No fee shall be charged for inspection of contract files, but 24-hours notice to the RFQ Coordinator is required. All requests for information should be directed to the RFQ Coordinator.

2.18. **Response Review by RFQ Coordinator**

Responses will be evaluated strictly in accordance with the requirements set forth in this RFQ and any amendments that may be issued. All responses will be reviewed by the RFQ Coordinator for completeness and compliance with the administrative requirements and instructions specified in this RFQ. Responsive responses will advance to the evaluation teams. Please use the checklist provided as Exhibit D for your convenience. Responses that fail to provide specific information to adequately describe their response to any question contained in this RFQ will be deemed non-responsive and shall be rejected. A response of "will comply" or "meets requirement" is not sufficient and will be deemed non-responsive. The RFQ Coordinator may contact the RSN for clarification of any portion of the RSN's response.

While DSHS reserves the right for its evaluation team to contact RSNs for clarification,

RSNs should not assume that deficient answers will result in clarification requests. The right of clarification is not a RSN's right, it is DSHS' right and DSHS expects to be very stringent in the exercise of this right.

2.19. **Evaluation, Scoring and Criteria**

2.19.1. **Initial Screening, Qualitative Review, and Scoring**

Responses that pass the Administrative Screening will be evaluated and scored based upon RSN's answers to the specific requirements of the RFQ. The evaluators will consider how well the RSN meets the requirements. It is important that the responses be clear and complete so that the evaluators can adequately understand all aspects of the response.

2.19.2. **Mandatory Requirement**

A Mandatory Requirement (MR) is an essential need that must be met by the RSN. MRs are scored as pass or fail. DSHS will eliminate from the evaluation process any RSN not fulfilling all mandatory requirements. Questions that are MRs are identified in Section 3, Response Contents.

Failure to meet an MR, a score of "fail" is grounds for disqualification and shall be established by any of the following conditions:

2.19.2.1. The RSN States that an MR cannot be met.

2.19.2.2. The RSN fails to include information requested by or necessary to substantiate that a given MR has been met. Supplemental material may be referenced, but the answer must be complete in itself. An answer of "will comply" is not sufficient substantiation.

2.19.2.3. Response does not indicate current capability. Representations that future developments or plans will satisfy a requirement are not sufficient unless specifically allowed in the RFQ question.

2.19.2.4. The RSN presents the information requested by this RFQ in a manner inconsistent with the instructions Stated by any portion of this RFQ.

2.19.2.5. DSHS determines ~~in any manner~~ that the RSN is unable or unwilling to comply with one or more of the mandatory requirements.

2.19.3. **Mandatory Scored Requirements**

A mandatory scored requirement (MSR) is an essential DSHS need that must be met by the responder. RSNs are required to respond to all MSRs. Questions that are MSRs are identified in Section 3, Response Contents.

Evaluators will score MSR on a scale of 0 to 5 points. A score of 0 is grounds for disqualification and shall be established by any of the following:

2.19.3.1. The RSN States that an MSR cannot be met.

2.19.3.2. The RSN fails to include information requested by or necessary to substantiate that a given MSR has been met. Supplemental material may be referenced, but the answer must be complete in itself. An answer of "will comply" is not sufficient substantiation.

2.19.3.3. Response does not indicate current capability. Representations that future developments or plans will satisfy a requirement are not sufficient unless specifically allowed in the RFQ question.

2.19.3.4. The RSN presents the information requested by this RFQ in a manner inconsistent with the instructions Stated by any portion of this RFQ.

2.19.3.5. DSHS determines ~~in any manner~~ that the RSN is unable or unwilling to comply with one or more of the mandatory scored requirements.

To be considered substantially compliant and be eligible for award of contracts as a result of this RFQ, an RSN must receive 70% of the total available points for all MSRs.

Prior to executing contracts resulting from the RFQ, DSHS may, at its sole discretion, require an apparently successful RSN to submit a corrective action plan (CAP) to fully address compliance with any requirement where DSHS, in its sole judgment, considers the RSN's response less than fully compliant. The CAP is subject to review and approval by DSHS.

DSHS reserves the right to reject any response if the RSN does not submit an acceptable CAP.

2.19.4. **Basis of Evaluation**

The evaluation will be based only upon the response and not upon the evaluator's external experience with, or perception of, the RSN or upon RSN presentations made prior to the release of this document.

It is in the RSN's best interest, therefore, to be thorough and fully responsive in preparing its solutions (answers) to these requirements. Failure of the RSN to respond to any MSR is grounds for disqualification.

Points will be assigned based upon the evaluators' analysis of the effectiveness and efficiency of the RSN's response to each requirement.

2.19.5. **Evaluation Teams**

The evaluation of responses shall be accomplished by several evaluation teams, to be designated by DSHS. The evaluation teams will determine whether responses are responsive to the Mandatory Requirements (MR) and Mandatory Scored Requirements (MSR) Stated in this RFQ. The RFQ Coordinator and staff involved in RFQ development will not serve as evaluators, but may develop information for presentation to the teams. Responses will be evaluated strictly in accordance with the requirements set forth in this RFQ and any amendments that are issued.

Evaluation teams will award a single score for each for section marked as a Mandatory Scored Requirement (MSR) or Mandatory Requirement (MR). The evaluation teams will score independently of other teams. Upon completion of team scoring, the scores will be given to the RFQ Coordinator.

2.20. **Contract Award**

2.20.1. **Selection and Notification of Apparently Successful RSNs**

The RFQ Coordinator will review the final scores and recommend to DSHS management the Apparently Successful RSNs based upon the above criteria. DSHS will notify the Apparently Successful RSN on or about the date and time specified in the Procurement Schedule of the selection of the Apparently Successful RSN by written notice via mail, e-mail, and/or fax. DSHS will separately notify the Unsuccessful RSNs on or about the date and time specified in the Procurement Schedule of the non-selection of the Unsuccessful RSNs by written notice via mail, e-mail, and/or fax.

2.20.2. **Execution of the Contracts**

Apparently Successful RSNs will be expected to sign contracts with DSHS that are modeled on those attached as Exhibits B and C. Refusal to sign the contract or any subsequent amendment within thirty calendar days of delivery of the final contracts may result in cancellation of the award.

2.20.3. **Response Part of Contracts**

The specifications of this RFQ and the successful RSN's response may become part of the contracts. Additionally, DSHS may choose to verify any or all RSN representations that appear in the response. Failure of the RSN to produce results promised in the response or in actual use may result in elimination of the RSN from the evaluation process or in contract cancellation or termination.

2.21. **Debriefing and Protest Procedures**

2.21.1. **RSN Debriefing Conference**

2.21.1.1. RSNs who submitted a response that was not selected will be given the opportunity for a debriefing conference. The RFQ Coordinator must receive the request for a debriefing conference within two business days of the Notification of Unsuccessful RSNs via mail, e-mail, or fax. The debriefing must be held within three business days of the request.

2.21.1.2. Debriefing conferences may be conducted in person or on the telephone and will be scheduled for a maximum of one hour. Discussion at the debriefing conference will be limited to the following:

2.21.1.2.1. Evaluation and scoring of your response.

2.21.1.2.2. Critique of your response based on evaluators' comments.

2.21.1.2.3. Review of your final score.

2.21.2. **Protest Procedure**

2.21.2.1. Administrative Remedy

Protests may be made only after DSHS has sent notification to Apparently Successful RSNs and to the Unsuccessful RSNs. In order to submit a protest under this RFQ, a RSN must have submitted a response for this RFQ, and have requested and participated in a debriefing conference. It is the sole administrative remedy available within DSHS.

2.21.2.2. Grounds for Protest

A protest may be made based on these grounds only:

2.21.2.2.1. Arithmetic errors were made by DSHS in computing the score;

2.21.2.2.2. DSHS materially failed to follow the procedures established in this RFQ document, or to follow applicable State or federal laws or regulations; or

2.21.2.2.3. Bias, discrimination, or conflict of interest on the part of an evaluator.

2.21.2.3. Protest Form and Content

A protest must State all of the facts and arguments upon which the protest is based, and the grounds for your protest. It must be in writing and signed by a person authorized to bind the RSN to a contractual relationship. At a minimum, the protest must include:

2.21.2.3.1. the name of the protesting RSN, mailing address, and phone number, and the name of the individual responsible for submission of the protest;

2.21.2.3.2. The RFQ number and title.

2.21.2.3.3. A detailed and complete Statement of the specific action(s) by DSHS under protest.

2.21.2.3.4. The grounds for the protest.

2.21.2.3.5. A description of the relief or corrective action requested.

You may attach to your protest any documentation you offer to support your protest.

2.21.3. **Submitting a Protest**

Your protest must be in writing and must be signed. You must mail or hand deliver your protest to the RFQ Coordinator using the same mailing or delivery address provided in this RFQ for submitting your response. ***Protests may not be submitted by fax or email***. The RFQ Coordinator must receive the written protest within five business days after the debriefing conference.

2.21.3.1. Protest Process

2.21.3.1.1. The RFQ Coordinator will forward your protest to the DSHS-designated Protest Coordinator with copies of the following:

2.21.3.1.1.1. This RFQ and any amendments

2.21.3.1.1.2. Your response

2.21.3.1.1.3. The evaluators' scoring sheets

2.21.3.1.1.4. Any other documents showing evaluation and scoring of your response

2.21.3.1.2. DSHS will conduct an objective review of your protest, based on the contents of your written protest and the above materials provided by the RFQ Coordinator.

2.21.3.2. Final Determination

2.21.3.2.1. DSHS will send you a written decision within five business days after DSHS receives your protest, unless more time is required to review the protest and make a determination. The protesting RSN will be notified by the RFQ Coordinator if additional time is necessary.

2.21.3.2.2. DSHS will make a final determination of your protest and will find one of the following:

2.21.3.2.2.1. Find that your protest lacks merit and uphold DSHS' actions.

2.21.3.2.2.2. Find that any errors in the RFQ process or in DSHS' conduct did not influence the outcome of the RFQ, and uphold DSHS' actions.

2.21.3.2.2.3. Find merit in the protest and provide options for corrective action by DSHS which may include:

2.21.3.2.2.3.1. That DSHS correct any errors and re-evaluate all responses affected by its determination of the protest.

2.21.3.2.2.3.2. That DSHS reissue the RFQ document.

2.21.3.2.2.3.3. That DSHS make other findings and take such other action as may be appropriate.

2.21.3.2.3. If DSHS determines that the protest is without merit, DSHS will complete the procurement by contracting with Apparently Successful RSNs. If the protest is determined to have merit, one of the alternatives noted in the preceding paragraph will be taken.

2.21.4. **Legislative Testimony**

The RSN may be expected to testify before the Washington State Legislature at the conclusion of the project. The RSN must acknowledge and agree to the above condition.

3. RESPONSE CONTENTS

This section of the RFQ outlines the response contents: the requirements, qualifications, and questions that comprise the response narrative. Any requirement and question not identified as being for either the Title XIX or State Funded Program is a requirement and question for both programs. The response will have five sections:

3.1 Special Initiatives
3.2 Administrative and Financial Requirements
3.3 Information System Requirements
3.4 RSN Program Requirements
3.5 Tribal Authority Relationships

3.1. Special Initiatives

3.1.1. This section of the RFQ includes special initiatives mandated in recent Washington State legislation and those that require interagency collaboration.

3.1.2. During 2005, new legislation that was signed into law provides a vision and direction for the Washington State mental health system:

3.1.2.1. Engrossed Second Substitute Senate Bill 5763 (E2SSB 5763), addresses the need to provide integrated treatment and reduce the disproportionate number of persons with mental disorders, chemical dependency disorders, or co-occurring mental and substance abuse disorders who are in correctional institutions, homeless, or become involved with child protective services, a dependency proceeding, or lost State and federal benefits as a result of their disorders.

3.1.2.2. Engrossed Second Substitute House Bill 1290 (E2SHB 1290) mandates the following requirements:

3.1.2.2.1. Consumer, family member, and advocate participation in all aspects of service delivery.

3.1.2.2.2. Provision of services that emphasize resilience and recovery.

3.1.2.2.3. Access to evidence-based, research-based, and consensus-based practices.

3.1.2.2.4. Adequate residential and service capabilities, including all services in the Mental Health State Plan (addressed in RFQ Section 3.4).

3.1.2.2.5. Collaboration with Justice and chemical dependency services.

3.1.2.2.6. Medicaid eligibility for incarcerated persons leaving jails and prisons.

3.1.2.2.7. Continuation of the Mental Health Task Force to oversee reorganization of the MHD, establishment of RSNs through procurement, the funding distribution methodology, services for non-Medicaid consumers, and access to inpatient psychiatric hospital and community residential beds.

3.1.3. **Consumer Participation Requirements**

The RSN and its subcontractors shall address the following requirements:

3.1.3.1. Provide information to consumers, families, and service providers on mental health and the models of client-driven services that are developing nationally and internationally.

3.1.3.2. Encourage and facilitate the development of consumer-operated services.

3.1.3.3. ~~Employ~~ Involve consumers and family members as participants in governance, administration, service delivery, and evaluation.

3.1.3.4. Develop and implement policies and procedures that enhance participation of consumers and family members in the development of individual service plans and monitor provider subcontractors for compliance with this requirement.

3.1.3.5. Include consumers and their family members in the planning for service coordination among State and local agencies, including those that provide services to children and elders, justice agencies, K -12 schools, and among State psychiatric hospitals, county authorities, community mental health services, and other support services.

3.1.3.6. Include representatives of consumers and families as members of the Mental Health Advisory Board that provides oversight and problem resolution of its regional service delivery system.

3.1.4. **Consumer Participation Questions (MSR)**

Describe your past experience and approach to promoting consumer involvement both within the RSN and the subcontracted providers and specific plans for Fiscal Year (FY) 2007. Address the following requirements:

3.1.4.1. Provision of information to consumers, families, and service providers on developing models of client driven services.

3.1.4.2. Involvement of consumers and family members as participants in governance, administration, service delivery, and evaluation.

3.1.4.3. Development and implementation of policies and procedures that enhance participation of consumers and family members in individual service planning, and RSN monitoring of provider subcontractors for compliance with this requirement.

3.1.4.4. Inclusion of consumers and their families in the planning for coordination of services among State and local agencies, including those that provide services to children and elders, justice agencies, K – 12 schools, and among State psychiatric hospitals, county authorities, community mental health services, and other support services.

3.1.4.5. Inclusion of consumers and families on the Mental Health Advisory Board that provides oversight and problem resolution of the regional service delivery system.

3.1.4.6. Current services operated consumers and future plans for facilitating the development of consumer-operated services.

3.1.5. **Promoting Recovery and Resilience Requirements**

3.1.5.1. The RSN shall promote the use of recovery and resilience oriented services.

3.1.5.2. The RSN shall provide ongoing training and information to its staff and subcontracted providers on strategies and services that promote wellness, recovery, and resilience. The training and information shall emphasize the following principles:

3.1.5.2.1. Mental health will be understood as an essential element of overall health.

3.1.5.2.2. Mental illness shall be understood as a condition from which people can and do recover.

3.1.5.2.3. Recovery from mental illness involves regaining a sense of purpose and control over one's life that overcomes, to the extent possible, limitations imposed by the illness.

3.1.5.2.4. Recovery-oriented approaches provide opportunities for consumers to manage their mental illness; rebound from adversity, trauma, tragedy, threats, or other stresses; maintain their independence; and live productive lives.

3.1.5.3. The RSN shall integrate wellness/recovery models into culturally competent individualized service plans. The individualized service plan shall include information on quality of life outcomes, as desired by the consumer.

3.1.6. **Promoting Recovery And Resilience Questions (MSR)**

3.1.6.1. Describe the RSN's experience with, knowledge of, and approach to promoting recovery and resilience.

3.1.6.2. Describe how the RSN assists subcontracted providers with understanding and implementing tools and supports that promote recovery and resilience.

3.1.6.3. Describe how the RSN provides training and information to staff and subcontracted providers on recovery and resilience.

3.1.6.4. Describe how the RSN involves consumers and families in the development of wellness and recovery based services.

3.1.6.5. Describe how cultural and diversity needs of individuals are identified and addressed.

3.1.6.6. Describe how the individual service plan reflects recovery and resilience principles including cultural competence.

3.1.6.7. Describe how the RSN will track an individual's quality of life outcomes. At a minimum include education, employment and self-directed care.

3.1.7. **Evidence-Based, Research-Based, Consensus-Based, and Promising or Emerging Best Practices Requirements**

3.1.7.1. The RSN shall integrate evidence-based practices into its provider network. The use of evidence-based practices is an explicit priority. The following ~~eight~~ nine core evidence-based practices have been selected by DSHS for implementation.

~~Eight (8)~~Nine (9) CORE Evidence-Based Practices

Adults	Assertive Community Treatment	Family Psychological Education	Supported Employment	Dialectic Behavior Therapy
Children	Multi-Systemic Therapy	Functional Family Therapy	Multi-Dimensional Treatment Foster Care	Trauma Focused Cognitive Behavioral Therapy
Co-Occurring Disorders	Co-Occurring Mental Health/Chemical Dependency Treatment			

3.1.7.2. The following additional evidence-based and promising practices have been selected by DSHS as priorities for implementation.

3 PRIORITY Evidence-Based/Promising Practices

Adults	Illness Self Management	
Children	Wrap Around	Dialectic Behavior Therapy
Older Adults	Gatekeeper for Older Adults	Medication Algorithms

3.1.7.3. The RSN must have written policies and procedures addressing the adoption of evidence-based, research-based, consensus-based, and promising or emerging best practices. The policies and procedures must address the following areas:

3.1.7.3.1. Implementation of DSHS Core Evidence Based Practices and Priority Promising practices.

3.1.7.3.2. Review of cultural competence and appropriateness of research-based, consensus-based, and promising practices for ethnic, racial, and cultural minorities living within the RSN's geographic boundaries and adoption of practices that address ethnic, cultural, and linguistic needs.

3.1.7.3.3. Consumer, family member, and advocate input into the prioritization and implementation and of such practices.

3.1.7.3.4. Methods to promote consensus and implement such practices among subcontracted providers.

3.1.7.3.5. Tools and methods to promote and monitor fidelity to such practices.

3.1.7.3.6. Oversight efforts to ensure the service providers are fully utilizing evidence-based, research-based, consensus-based, and promising or emerging practices.

3.1.8. **Evidence-Based, Research-Based, Consensus-Based, and Promising or Emerging Best Practices Questions (MSR)**

3.1.8.1. Describe the core practices available in the RSNs provider network. List the organizations providing such practices and the number of consumers currently being served as of August 1, 2005. Describe your plans to increase access to the core practices. Identify any other evidence-based practices in use within your provider network.

3.1.8.2. Describe the additional evidenced based promising practices prioritized by DSHS available in the RSN's provider network. List the organizations

providing such practices and the number of consumers currently being served as of August 1, 2005. Describe your plans to increase access to the additional practices. Identify any other promising or emerging practices in use within your provider network.

3.1.8.3. Provide written policies and procedures, which have been formally adopted by the RSN, addressing evidence-based, research-based, consensus-based, and promising or emerging best practices.

3.1.9. **Allied System Coordination Requirements**

3.1.9.1. The RSN shall develop a written allied system coordination plan for each of the following programs:

3.1.9.1.1. Aging and Disability Services Administration (ADSA)

3.1.9.1.2. Chemical Dependency and Substance Abuse services

3.1.9.1.3. Children's Administration

3.1.9.1.4. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans

3.1.9.1.5. Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections)

3.1.9.1.6. Division of Vocational Rehabilitation

3.1.9.1.7. Juvenile Rehabilitation Administration

3.1.9.1.8. K-12 Education System

3.1.9.2. Each allied system coordination plan must contain the following:

3.1.9.2.1. Clarification of roles and responsibilities of allied systems in serving persons mutually served.

3.1.9.2.2. Processes for sharing of information related to eligibility, access, and authorization.

3.1.9.2.3. Identification of needed local resources, including initiatives to address those needs.

3.1.9.2.4. Process for facilitation of community reintegration from out-of-home placements (e.g., State hospitals, CLIP, Juvenile Rehabilitation

Administration facilities, foster care, skilled nursing facilities, acute inpatient settings) for consumers of all ages.

3.1.9.2.5. A process to address disputes related to service or payment responsibility.

3.1.9.2.6. A process to evaluate cross-system coordination and integration of services.

3.1.9.3. If a plan does not exist, the plan shall be developed by September 1, 2006,

3.1.9.4. The plan for ADSA must also specifically address for the Division of Developmental Disabilities:

3.1.9.4.1. Admission and discharge of persons to the State's Psychiatric Hospitals, including oversight of discharge planning for individuals served by the State psychiatric hospitals who are also enrolled with DDD.

3.1.9.4.2. Managing crisis and the use of joint resources to address the crisis (e.g., assessing if the crisis is related to loss of housing, psychiatric issues, behavior management and identification of services and supports to mitigate the crisis).

3.1.9.5. The plan for Chemical Dependency and Substance Abuse services must also specifically address:

3.1.9.5.1. Protocols for assessing the presence of co-occurring disorders.

3.1.9.5.2. Provision of integrated treatment for persons with co-occurring disorders.

3.1.9.5.3. Use of evidence-based, research-based, and consensus-based practices for persons with co-occurring disorders.

3.1.9.6. The plan for Children's Administration must also specifically address:

3.1.9.6.1. Availability of an intake to all Medicaid enrolled children, including children in foster care.

3.1.9.6.2. Availability of culturally-competent, evidence-based, consensus-based, and promising practices for children, especially for children with multiple agency involvement (e.g., dependency court, protective services, foster care, mental health, juvenile rehabilitation).

3.1.9.7. The plan for community health clinics, federally qualified health centers (FQHCs), and healthy options plans must also specifically address:

3.1.9.7.1. Protocols for accessing health and mental health services for persons mutually served.

3.1.9.7.2. Coordination of care with primary care physicians or other health professionals.

3.1.9.8. The plan for criminal justice organizations must also specifically address:

3.1.9.8.1. For State funded Jail Services address:

3.1.9.8.1.1. Coordination with local law enforcement and jail personnel, which detail a referral process for individuals with mental illness who are incarcerated and need mental health services.

3.1.9.8.1.2. Identification and provision of transition services to individuals with mental illness to expedite, facilitate, and coordinate their return to the community.

3.1.9.8.1.3. Identification and acceptance of referrals for intake of individuals who are not enrolled in community mental health services but who meet priority populations as defined in 71.24. The RSN shall conduct mental health intake assessments for these individuals and provide transition services prior to their release from jail.

3.1.9.8.2. For Department of Corrections address coordination with any Dangerous Mentally Ill Offender program in the RSN service area for which the RSN is not the DMIO contractor with MHD.

3.1.9.9. The plan for the regional office of Division of Vocational Rehabilitation must also specifically address processes for collaboration regarding supported employment and other related employment services (e.g., clubhouse, work readiness).

3.1.10. **Allied System Coordination Questions (MSR)**

3.1.10.1. Provide written policies and procedures, which have been formally adopted by the RSN, for working collaboratively with and establishing written allied system coordination plan for the organizations named in the requirements.

3.1.10.2. Provide all current written allied system coordination plans. Plans must include the specific plan requirements described above for each program.

3.1.10.3. If a written allied system coordination plan is not in place provide a description of the current process for coordination of care for persons mutually served. Include the specific plan requirements described above for each program.

3.1.10.4. If a plan does not exist, provide a project plan including a schedule for the development of a coordination of care plan by September 1, 2006.

3.2. **Administrative and Financial Requirements**

3.2.1. **Letter of Submittal Requirements and Questions (MR)**

RSNs must provide a Letter of Submittal on RSN's official business letterhead stationery. The letter must be included as the first page of the RSN's response. The letter must be signed and dated by an individual with full authority to legally bind the entity submitting the response to this RFQ. Signing the submittal letter indicates that the RSN accepts the terms and conditions of this RFQ and that the RSN acknowledges and agrees to all of the rights of DSHS including the RFQ rules and procedures, terms and conditions and all other rights and terms specified in this RFQ, including any amendments.

The RSN's Letter of Submittal must include the following:

3.2.1.1. The name, address, principal place of business, telephone number, fax number, and e-mail address of legal entity or individual with whom contracts would be written.

3.2.1.2. The name of your contact person for this RFQ.

3.2.1.3. The location of the facility from which the RSN operates.

3.2.1.4. A detailed list of all materials and enclosures included in your response.

3.2.1.5. A list of all RFQ amendments downloaded by the RSN from DSHS Procurements Web site, if applicable, and listed in order by amendment number and date; if there are no RFQ amendments; include a Statement to that effect.

3.2.1.6. Identification of the page numbers on the RSN's response that are marked "Proprietary or Confidential" information.

3.2.1.7. Any Statements you wish to convey to the RFQ Coordinator, including any variations between your response and the RFQ.

3.2.2. **Certifications and Assurance Forms Requirements and Questions (MR)**

Complete Exhibit A – **RSN Information, Certifications, and Assurance Form** signed

by an authorized representative of the RSN. Please include any necessary attachments.

3.2.3. **Administrative and Organizational Capacity Requirements**

3.2.3.1. RSNs must demonstrate the administrative capacity and organizational stability to operate a PIHP to provide medically necessary MH services to enrollees pursuant to:

3.2.3.1.1. CFR 42 CFR 438, or any successors and Federal 1915 (b) MH Waiver, Medicaid State plan or any successors.

3.2.3.1.2. Other provisions of Title XIX of the Social Security Act, or any successors.

3.2.3.1.3. RCW 70.02, 71.05, 71.24, and 71.34, or any successors.

3.2.3.1.4. WAC 388-865 or any successors.

3.2.3.1.5. Other applicable State and federal statutes and regulations, or any successors.

3.2.3.2. RSNs must have the administrative capacity and organizational stability to provide or purchase age, linguistic and culturally competent and community MH services for individuals for whom services are medically necessary and clinically appropriate pursuant to:

3.2.3.2.1. RCW 38.52, 70.02, 71.05, 71.24, and 71.34, or any successors; WAC 388-865 or any successors.

3.2.3.2.2. Other applicable State and federal statutes and regulations, or any successors.

3.2.3.2.3. DSHS Administrative policies or any successors.

3.2.3.3. The RSN shall have adequate professional staff in place to perform all functions of the contracts.

3.2.4. **Administrative and Organizational Capacity Questions (MSR)**

3.2.4.1. Describe the RSN's history, knowledge, experience, size, areas of specialization, and capability to provide the services as specified in this RFQ and how these will support the RSN in fulfilling the requirements and principles of the RFQ. The description should differentiate the Title XIX program and State-only services, if different. Please describe examples of how the RSN has been successful in achieving systems and principles similar to those outlined in this RFQ (Limit 5 pages).

3.2.4.2. Describe the RSN's organizational structure and office locations, including responsibility, authority, communication, and coordination between and within the departments. Describe how the RSN's administrative structure will support the service requirements as described in this RFQ. As part of this answer, submit a detailed organization chart with job function, job description, and the qualifications of the person holding the position for each of the following administrative functions: administration; finance; and information systems. Provide an organization chart, indicating the key director or supervisory level staff and the number of full-time equivalents (FTEs) in each functional area sufficient to fulfill the requirements of this RFQ. The organizational chart must describe the high level reporting relationships and number of full-time equivalent staff for the following functions:

3.2.4.2.1. Psychiatric medical direction

3.2.4.2.2. Care management/resource management/utilization management

3.2.4.2.3. Quality management

3.2.4.2.4. Provider contracting and network management

3.2.4.2.5. Customer services

3.2.4.2.6. Grievances and appeals

3.2.4.3. Identify any function or service the RSN intends to delegate or subcontract. Provide detailed description of the delegation plan and subcontracting arrangements, including (1) name, address, and telephone number of the subcontractor(s), (2) owners of the organization, (3) specific contracted services, (4) compensation arrangement, and (5) monitoring plan. Submit a copy of existing or draft subcontracting agreement. Please note that certain RSN functions may not be delegated as specified in this RFQ.

3.2.5. **Financial Stability and Viability Requirements**

The RSN must have the financial ability to accept payments on an at-risk basis and have sufficient financial resources to remain solvent.

3.2.6. **Financial Stability and Viability Questions (MSR)**

Discuss and provide evidence of your financial status, solvency, and viability. The materials submitted must demonstrate the RSN's financial ability to accept payments on an at-risk basis and have sufficient financial resources to remain solvent.

The RSN shall provide to MHD copies of its annual audit to verify its financial status, solvency, and viability. Annual audited financial Statements shall be audited in accordance with Generally Accepted Auditing Standards by an independent Certified Public Accountant (CPA). If the RSN does not have audited financial Statements as described above, the RSN may provide annual reports, financial Statements, and other reports in response to this section. The RSN shall submit financial Statements in accordance with Generally Accepted Accounting Principals (GAAP). Materials submitted must be sufficient to indicate the organizational stability and financial strength of the RSN. These alternative reports and Statements must be prepared by an independent CPA and at a minimum include a Balance Sheet, Income Statement, and Statement of Cash Flow.

If no financial Statements as indicated above are available or the financial Statements provided do not show the RSN to financially stable and viable, the RSN must provide a written Financial Guarantee from the respective County(ies) that any losses that the RSN incurs will be covered by the County(ies). In such a case, the audited financial Statements of the County(ies) should be provided in conjunction with the Financial Guarantee.

3.2.7. **Accounting and Internal Control Requirements**

The RSN shall have sufficient internal controls and systems in place designed to account for Contract-related and non-Contract-related revenues and expenses separately. The RSN must ensure that all funds received by the RSN shall be accounted for by tracking Title XIX Medicaid revenue and expenditures separately from other funding sources and be reported separately as required by MHD. The RSN must ensure that all funds including interest earned, provided pursuant to the resulting contracts are used to support the public MH system. In addition, the RSN must account for public MH expenditures in accord with the BARS Manual and BARS Supplemental Instructions.

3.2.8. **Accounting and Internal Control Questions (MR)**

3.2.8.1. Describe the steps taken by the RSN to implement internal control systems surrounding financial accounting and the steps taken to ensure that contract-related revenues and expenses are reported separately.

3.2.8.2. Identify all processes and procedures implemented to ensure that public MH expenditures are accounted for in accordance with the BARS Manual and Supplemental Instructions.

3.2.8.3. Submit evidence of all internal controls surrounding financial accounting, reporting, and BARS Manual compliance.

3.2.9. **Report Submission Requirements**

3.2.9.1. The RSN is responsible for submitting complete financial reports accurately and in a timely manner. MHD shall furnish the RSN with timely notice of reporting requirements, including acceptable reporting formats, instructions, and timetables for submission.

3.2.9.2. Reports or other data shall be received on or before the scheduled due date. All required reports shall be received by MHD no later than 5:00 p.m. Pacific Time on the due date. Requests for extensions shall be submitted to MHD in writing and MHD shall use its own discretion in determining whether to approve or deny the request.

3.2.10. **Report Submission Questions (MR)**

3.2.10.1. Describe the process and procedures in place to ensure reports are complete accurate and submitted in a timely manner to MHD.

3.2.10.2. Provide a description of the RSN's accounting and information system and the RSN's ability to implement changes in reporting requirements or provide ad-hoc data requests as required by MHD.

3.2.10.3. Describe how the RSN measures and reports outcomes for the requirements.

3.2.11. **Management Attestation Requirements**

3.2.11.1. The RSN must ensure plans or reports required by the RSN contracts are provided to MHD in compliance with the timelines and/or formats determined by MHD. Encounter and fiscal data, which the RSN contracts require the RSN to submit to MHD, shall be certified in writing as set forth in 42 CFR 438.606. The certification shall be made by one of the following individuals:

3.2.11.1.1. The RSN's Chief Executive Officer (CEO).

3.2.11.1.2. The RSN's Chief Financial Officer (CFO).

3.2.11.1.3. An individual who has delegated authority to sign for, and who reports directly to the RSN's CEO or CFO.

3.2.11.2. The certification shall attest based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of the documents

and data. The RSN shall submit the certification concurrently with the certified data and documents.

3.2.12. **Management Attestation Question (MR)**

Provide written policies and procedures, which have been formally adopted by the RSN, that address management certification including how information submitted to MHD is reviewed by management to ensure accuracy prior to management's certification.

3.2.13. **Administrative Expense Requirements**

The RSN shall limit administration costs, in accord with the BARS Manual and Supplemental Instructions, incurred by the RSN to no more than 10 percent of available funds supporting the public MH system operated by the RSN. Administration costs must be measured on a fiscal year basis according to the reported information submitted by the RSN in their Revenue and Expenditure reports and reviewed by MHD.

3.2.14. **Administrative Expense Questions (MSR)**

3.2.14.1. Describe the processes in place to ensure that administration costs will be limited to 10 percent.

3.2.14.2. Provide separate budgets for the Title XIX and State funded program funds covering the period of October 1, 2005, through September 30, 2006, based upon revenue identified in the RSN PIHP and State Funded Contracts for the period of September 1, 2005 through August 31, 2006.

3.2.15. **Third Party Resources Requirements**

The RSN shall ensure a process is in place to demonstrate that all third-party resources are identified, pursued, and recorded in accordance with Medicaid being the payer of last resort. All funds recovered by the RSN from third-party resources shall be treated as income and will be used to support the public MH system.

3.2.16. **Third Party Resources Questions (MSR)**

3.2.16.1. Describe the methodologies in place to ensure that all third-party resources are identified.

3.2.16.2. Describe the procedures in place to ensure that third party resources are pursued and that those monies are utilized to support the public MH system.

3.2.16.3. Describe how any monies recovered from third-party payers are recorded.

3.2.16.4. Provide written policies and procedures, which have been formally adopted by the RSN, that address third-party liability and coordination of benefits requirements.

3.2.16.5. Describe how the RSN measures and reports outcomes for the requirements.

3.2.17. **Timeliness of Provider Payment Requirements**

Payments to providers by the RSN shall be made on a timely basis, consistent with claims payment procedures described in 1902(a)(37)(A) of the Social Security Act and 42 CFR 447.45. The RSN shall ensure that 90 percent of all clean claims for covered services, for which no further written information or substantiation is required in order to make payment, are paid within 30 days of the date of approval; and that 99 percent of such claims are paid within 180 days of the date of receipt.

3.2.18. **Timelines Of Provider Payment Questions (MR)**

3.2.18.1. For claims that result in actual cash payments to providers, describe how the RSN ensures that claims are paid timely and the methods implemented to monitor claim timeliness and payment accuracy.

3.2.18.2. Describe how the RSN measures and reports outcomes for the requirements.

3.2.19. **Provider Claim Disputes Requirements**

The RSN shall develop and implement a provider claim disputes process in accordance with all applicable federal and State laws. When the RSN denies a claim, the RSN shall notify the provider in writing of the claim denial and inform the provider of the right to appeal and the specific procedure to file an appeal.

3.2.20. **Provider Claims Disputes Questions (MR)**

Describe the RSN's provider claim dispute process. Describe the RSN's plan to provide prompt resolution to claims disputes.

3.2.21. **Payments From Medicaid Enrollees Requirements**

The RSN must ensure that Medicaid enrollees are not charged for Medicaid covered services including, out-of-network, and are not held liable for any of the following:

3.2.21.1. Insolvent community psychiatric hospitals with which the RSN has directly contracted. The RSN is specifically exempt from the requirements of 42 CFR §438 regarding solvency.

3.2.21.2. Covered MH services, including those purchased on behalf of the enrollee.

3.2.21.3. Covered MH services provided to the enrollee for which the State does not pay the RSN or the RSN does not pay the MHCP or CMHA that furnishes the services under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the enrollee would owe if the RSN provided the services directly.

3.2.22. **Payments From Medicaid Enrollees Questions (MR)**

3.2.22.1. Describe the procedures utilized to monitor the financial solvency of the Network Providers.

3.2.22.2. Describe how the RSN ensures that Medicaid enrollees are not charged for covered services.

3.2.23. **Fraud and Abuse Requirements**

3.2.23.1. In the context of Fraud and Abuse Requirements, abuse means a provider practice that is inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care (Medicaid Managed Care Fraud and Abuse Guidelines).

3.2.23.2. In the context of Fraud and Abuse Requirements, fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or State law (Medicaid Managed Care Fraud and Abuse Guidelines).

3.2.23.3. The RSN shall have administrative and management arrangements or procedures designed to guard against fraud and abuse. The RSN arrangements and procedures shall include the following:

3.2.23.3.1. A procedure to verify whether services reimbursed by Medicaid were actually furnished to enrollees.

3.2.23.3.2. Written policies, procedures, and standards of conduct that articulate the RSN's commitment to comply with all applicable federal and State standards.

3.2.23.3.3. The designation of a compliance officer and a compliance committee accountable to senior management.

3.2.23.3.4. Effective training and education for the compliance officer and employees.

3.2.23.3.5. Effective lines of communication between the compliance officer and employees.

3.2.23.3.6. Enforcement of standards through well-publicized disciplinary guidelines.

3.2.23.3.7. Provision for internal monitoring and auditing.

3.2.23.3.8. Provision for prompt response to detected offenses, and for development of corrective action initiatives relating to the contracts.

3.2.23.4. The RSN shall have a mandatory Compliance Plan designed to guard against fraud and abuse.

3.2.24. **Fraud And Abuse Questions (MR)**

3.2.24.1. Provide policies and procedures, which have been formally adopted by the RSN that address the Fraud and Abuse requirements.

3.2.24.2. Provide a description of internal controls regarding fraud and abuse.

3.2.24.3. Submit the RSN's Compliance Plan designed to guard against fraud and abuse.

3.2.24.4. Describe how the RSN measures and reports outcomes for the requirements.

3.2.25. **Sentinel Events and Negative Media Coverage Requirements**

3.2.25.1. The RSN must notify MHD of any incident when there is sentinel event and/or negative media coverage expected. Examples of incidents to report include, but are not limited to: homicide, attempted homicide, completed suicide, abuse or neglect of an enrollee by an employee or volunteer, loss of crisis lines, or loss of service or residential sites.

3.2.25.2. Notification must be made the MH services Chief or his/her designee during the business day in which the RSN becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

3.2.25.3. Notification must include a description of the event, any actions taken in response to the incident, the purpose for which any action was taken, and any implications to the service delivery system.

3.2.25.4. When requested, a written report will be provided within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.

3.2.26. **Sentinel Events And Negative Media Coverage Questions (MR)**

3.2.26.1. Describe the steps taken by the RSN to notify MHD of sentinel events and/or negative media coverage.

3.2.26.2. Provide written policies and procedures, which have been formally adopted by the RSN, addressing negative media identification and reporting to MHD.

3.3. Information System Requirements

3.3.1. Encounter Data Requirements

3.3.1.1. RSN shall submit all encounters to MHD in accordance with current Consumer Information System (CIS) specifications and/or industry standards as outlined in the Health Information Portability and Accountability Act (HIPAA) electronic data interchange (EDI) file formats.

3.3.1.2. HIPAA format 837P is used to submit encounters for all professional (non-Institutional) services. HIPAA format 837I is used to submit encounters for most hospital services including outpatient, inpatient, and residential settings.

3.3.1.3. It is the RSN's responsibility to provide valid and usable encounter data to MHD. To this end, the RSN shall ensure that data received from providers is accurate and complete by:

3.3.1.3.1. Verifying the accuracy and timeliness of reported data.

3.3.1.3.2. Screening the data for completeness, logic, and consistency.

3.3.1.3.3. Collecting service information in standardized formats to the extent feasible and appropriate.

3.3.1.3.4. Collecting service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.

3.3.1.4. The RSN shall submit encounters to MHD via an electronic record showing every encounter between a provider and a consumer within 60 days of the close of the month in which the specific encounter occurred.

3.3.1.5. Encounters will be analyzed by MHD for accuracy and may be returned to the RSN for resubmission. In the event the encounter is rejected an explanation for the disallowance will be provided. The RSN must develop error handling process that includes correction of the erroneous data and resubmission capabilities. The RSN must also require subcontractors to develop error handling processes that include correction of the erroneous data and resubmission capabilities.

3.3.2. **Encounter Data Questions (MSR)**

3.3.2.1. Describe the RSN's Electronic Data Interchange environment including services and processes for creating, verifying, and sending all encounters to the State, including encounters submitted by subcontractors.

3.3.2.2. Provide copies of submission reports that are generated during the encounter submission process, both from subcontractors to the RSN and from the RSN to MHD.

3.3.2.3. Provide written policies and procedures, which have been formally adopted by the RSN, regarding the submission of encounters.

3.3.2.4. Provide examples of subcontract claims lag reports that demonstrate subcontractor claims, if applicable, are paid and encounters submitted within 60 days from the ~~encounter date~~ close of the calendar month in which the encounter occurred.

3.3.2.5. Provide written policies and procedures, which have been formally adopted by the RSN that address and describe processes for error resolution and encounter resubmission both from subcontractors to the RSN and from the RSN to MHD.

3.3.2.6. Describe how the RSN measures and reports outcomes for the requirements.

3.3.3. **Enrollment And Demographic Data Requirements**

3.3.3.1. RSN shall receive client eligibility and demographic information in accordance with current CIS specifications.

3.3.3.2. The RSN must be able to receive electronic eligibility information that will be used to establish or terminate client eligibility. RSN must also be able to process retroactive changes in a client's status. Claims affected by eligibility retroactivity must be re-processed based on the new client status.

3.3.3.3. The RSN must be able to modify their information systems within 120 days of the date of published changes to the data dictionary. If the RSN uses an

independent vendor to make changes, the vendor's must have the ability to make required changes within the timeframe.

3.3.4. **Enrollment and Demographic Data Questions (MR)**

3.3.4.1. Provide copies of all enrollment and eligibility reports that demonstrate accurate receipt, processing, and reconciliation.

3.3.4.2. Provide written policies and procedures, which have been formally adopted by the RSN, addressing the loading all enrollment, demographic data, and eligibility updates into an information system.

3.3.4.3. Provide documentation that describes how the RSN will to meet the requirement to modify their information systems within 120 days of the date of published changes to the data dictionary. If the RSN uses an independent vendor to make changes, supply documentation that describes the vendor's agreement and ability to make required changes within contracted timeframes.

3.3.4.4. Describe how the RSN measures and reports outcomes for the requirements.

3.3.5. **Reporting Requirements**

The RSN shall maintain an information system that supports the management and oversight of Medicaid waiver and State funded services. The RSN shall maintain an information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas such as utilization, grievances and appeals, and encounter submission information. The RSN must have a system disaster recovery plan.

3.3.6. **Reporting Questions (MR)**

3.3.6.1. Provide a description of your data reporting environment including data repositories and system diagrams.

3.3.6.2. Provide encounter submission reports that show number of records sent and accepted by RSN information system from subcontractors as well as submission reports that show number of records sent and accepted by MHD from RSN.

3.3.6.3. Describe how security of the data, systems, and software is achieved.

3.3.6.4. Provide written policies and procedures, which have been formally adopted by the RSN, for ensuring system recoverability both for RSN information systems and for those of subcontractors.

3.3.6.5. Provide written policies and procedures, which have been formally adopted by the RSN, for providing a primary and backup system for electronic submission of data to MHD.

3.3.6.6. Provide written policies and procedures, which have been formally adopted by the RSN, that address how RSN information system is used for utilization review and resource management.

3.4. RSN Program Requirements

3.4.1. Title XIX Service Requirements

3.4.1.1. The RSN is required to provide services that assist the enrollee's progress toward recovery and resiliency and promotes linkages to other formal and informal systems.

3.4.1.2. Enrollees have access to the following benefits based on the Medicaid State Plan prior to an intake evaluation:

3.4.1.2.1. Crisis Services

3.4.1.2.2. Evaluation and Treatment

3.4.1.2.3. Stabilization; and Rehabilitation Case Management

3.4.1.2.4. Psychiatric Inpatient Services

3.4.1.3. All Medicaid enrollees requesting covered mental health services must be offered an intake evaluation as defined in the Medicaid State Plan. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.

3.4.1.4. Authorization for further services must be based on medical necessity and the Access to Care Standards. Enrollees denied an intake evaluation must receive a Notice of Action from the PIHP or its formal designee. Denials shall be tracked and reported to MHD in accordance with template provided.

3.4.1.5. Mental Health Rehabilitation Services are integrated treatment services recommended by a mental health professional and furnished by State licensed Community Mental Health Agencies, except for MH Clubhouse. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. Services shall be provided based on the following definitions, requirements and standards from the Medicaid State Plan or the 1915(b)(3) Waiver:

3.4.1.5.1. Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

3.4.1.5.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

3.4.1.5.3. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental

health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

3.4.1.5.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

3.4.1.5.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to: performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

3.4.1.5.6. Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

3.4.1.5.7. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, and neighbor). Other community agency members may include probation/parole officers*, teacher, minister, physician, chemical dependency counselor*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt

assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

3.4.1.5.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

3.4.1.5.9. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

3.4.1.5.10. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

3.4.1.5.11. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any

location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.

3.4.1.5.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

3.4.1.5.13. Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to

function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

3.4.1.5.14. Psychiatric Inpatient Services: 24-hour in-hospital beds for psychiatric services.

3.4.1.5.14.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300 (1) (d).

3.4.1.5.14.2. Effective September 1, 2006 the RSN must have a system in place to pay community hospitals directly without using DSHS as an intermediary.

3.4.1.5.14.3. Develop, maintain or purchase services for individuals who are involuntarily detained or committed in non-IMD community hospitals in accordance with RCW 71.05 or 71.34.

3.4.1.5.14.4. Provide or purchase psychiatric inpatient services when it is determined to be medically necessary for the following Title XIX eligible individuals:

3.4.1.5.14.4.1. Individuals under 22 years of age and over 65 years of age admitted to an Institute for Mental Disease (IMD) and have no other source of medical assistance.

3.4.1.5.14.4.2. Individuals who are voluntarily admitted to non-IMD community hospitals and have no other source of medical assistance.

3.4.1.5.14.4.3. Individuals who are involuntarily detained in non-IMD community hospitals in accordance with RCW 71.05 or 71.34.

3.4.1.5.15. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

3.4.1.5.16. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

3.4.1.5.17. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.

3.4.1.5.18. Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another

home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

3.4.1.5.19. Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment and individual treatment are not billable components of this service.

3.4.1.5.20. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary care givers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided

by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.

3.4.1.5.21. Supported Employment: A service for Medicaid enrollees who are currently neither receiving nor who are on a waiting list to receive federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

3.4.1.5.21.1. An assessment of work history, skills, training, education, and personal career goals.

3.4.1.5.21.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability.

3.4.1.5.21.3. Preparation skills such as resume development and interview skills.

3.4.1.5.21.4. Involvement with consumers served in creating and revising individualized job and career development plans that include:

3.4.1.5.21.4.1. Consumer strengths

3.4.1.5.21.4.2. Consumer abilities

3.4.1.5.21.4.3. Consumer preferences

3.4.1.5.21.4.4. Consumer's desired outcomes

3.4.1.5.21.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.

3.4.1.5.21.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

3.4.1.5.21.7. Services are provided by or under the supervision of a mental health professional.

3.4.1.5.22. Mental Health Clubhouse: A service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for

day support services. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

3.4.1.5.22.1. Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.

3.4.1.5.22.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.

3.4.1.5.22.3. Assistance with employment opportunities; housing, transportation, education and benefits planning.

3.4.1.5.22.4. Operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday.

3.4.1.5.22.5. Opportunities for socialization activities.

3.4.2. **Title XIX Services Questions (MSR)**

3.4.2.1. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will provide services that assist the enrollee's progress toward recovery and resiliency and promote linkages to other formal and informal systems. Include sufficient narrative to illustrate the RSN's understanding of and compliance with the requirement.

3.4.2.2. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will provide enrollees access to the following benefits, based on the Medicaid State Plan, prior to an intake evaluation. Describe in detail how **each** service is provided including facilities, staffing, staff qualifications and sufficient narrative to illustrate the RSN's understanding of service, understanding of the service requirements and compliance with the requirements:

3.4.2.2.1. Crisis Services

3.4.2.2.2. Evaluation and Treatment

3.4.2.2.3. Stabilization; and Rehabilitation Case Management

3.4.2.2.4. Psychiatric Inpatient Services

3.4.2.3. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will offer and provide Medicaid enrollees requesting covered mental health services an intake evaluation as defined in the Medicaid State Plan. A request for mental health services is

defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services. Include sufficient narrative to illustrate the RSN's understanding of and compliance with the requirement.

3.4.2.4. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will authorize services following an intake based on medical necessity and the Access to Care Standards, how enrollees denied an intake evaluation will receive a Notice of Action from the PIHP or its formal designee, and how denials shall be tracked and reported to MHD in accordance with template provided. Include sufficient narrative to illustrate the RSN's understanding of and compliance with the requirement.

3.4.2.5. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will provide Mental Health Rehabilitation Services that are integrated treatment services, recommended by a mental health professional, furnished by State licensed Community Mental Health Agencies, and provided to older adults, adults and children for whom the services are determined to be medically necessary. Describe in detail how **each** service described under 3.4.1.5. (3.4.1.5.1. to 3.4.1.5.22.) is provided including facilities, staffing, staff qualifications and sufficient narrative to illustrate the RSN's understanding of the service, understanding of the service requirements and compliance with the requirements.

~~3.4.2.6. Provide a written plan with a schedule describing how the RSN will have a system in place to pay community hospitals directly without using DSHS as an intermediary by September 1, 2006.~~

3.4.3. **State Funded Program Services Requirements**

3.4.3.1. Priority State Funded Services

The RSN is required to prioritize the use of available State funds to provide the following services:

3.4.3.1.1. Crisis Services: Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to

completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.

3.4.3.1.2. Stabilization Services: Services to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.

3.4.3.1.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 and 71.34. This includes all evaluation and monitoring services, costs related to court processes and transportation. Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional determines an individual must be evaluated for involuntary treatment. ITA services continue until the end of the involuntary commitment.

3.4.3.1.4. Ancillary Crisis Services: Includes costs associated with providing medically necessary crisis services not included in the Medicaid State Plan. Costs include but are not limited to the cost of room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities.

3.4.3.1.5. Freestanding Evaluation and Treatment: Services provided in inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to individuals who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to; performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and

pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

3.4.3.1.6. Psychiatric Inpatient Services: 24-hour in-hospital beds for psychiatric services.

3.4.3.1.6.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300 (1) (d).

3.4.3.1.6.2. Effective September 1, 2006 the RSN must have a system in place to pay community hospitals directly without using DSHS as an intermediary

3.4.3.1.6.3. Develop, maintain or purchase services for individuals who are involuntarily detained or committed in non-IMD community hospitals in accordance with RCW 71.05 or 71.34.

3.4.3.1.6.4. Provide or purchase psychiatric inpatient services when it is determined to be medically necessary for:

3.4.3.1.6.4.1. Individuals who agree to be admitted voluntarily and who are beneficiaries of the following State funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U).

3.4.3.1.6.4.2. Individuals who are involuntarily detained in accordance with RCW 71.05 or 71.34, and who are eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program.

3.4.3.1.6.4.3. Individuals at least 22 years of age and under 65 years of age who are Medicaid enrollees and are admitted to an Institute for Mental Disease (IMD).

3.4.3.1.7. Medicaid Personal Care: Respond to requests for Medicaid Personal Care (MPC) from the DSHS Aging and Disability Services Administration (ADSA) within 5 working days of the request. ADSA will use the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine service needed. The RSN may not limit or restrict authorization for these services due to insufficient resources. Authorization decisions must be based on the following:

3.4.3.1.7.1. A review of the request to determine if the individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the RSN's service area.

3.4.3.1.7.2. A verification that need for MPC services is based solely on the presence of a psychiatric disability.

3.4.3.1.7.3. A review of the requested MPC services to determine if the individual's needs could be met through provision of other available RSN services.

3.4.3.2. Additional State Funded Services

The RSN is required to prioritize any remaining funds following the provision of the Priority State Funded Services above to provide the following:

3.4.3.2.1. Residential Programs:

3.4.3.2.1.1. The full range of residential settings and programs must be available and provided based on the individuals needs, medical necessity and within available resources per the RSN's policies and procedures. The RSN must have contracts or memorandums of understanding to purchase a residential program outside of the RSN's service area when an individual requires a level of residential support which is not available from the RSN.

3.4.3.2.1.2. The full range of residential programs and settings include the following:

3.4.3.2.1.2.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.

3.4.3.2.1.2.2. Supervised living such as residential programs developed to serve individuals diagnosed with a major mental illness in Skilled Nursing Facilities, boarding homes or adult family homes.

3.4.3.2.1.2.3. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

3.4.3.2.2. Outpatient Mental Health Services

The descriptions and standards for State funded outpatient services are below.

3.4.3.2.2.1. Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to

ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the current level of functioning and assistance with self/care or life skills training. Individuals may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

3.4.3.2.2.2. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management, to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. To receive this service an Individual must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available up to 5 hours per day, 5 days per week.

3.4.3.2.2.3. Family Treatment: Psychological counseling provided for the direct benefit of the individual receiving services. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer.

Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

3.4.3.2.2.4. Group Treatment Services: Services provided to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

3.4.3.2.2.5. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, and neighbor). Other community agency members may include probation/parole officers, teacher, minister, physician, chemical dependency counselor, etc. Team member's work together to provide intensive coordinated and integrated treatment as described in the individual service plan.

The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

3.4.3.2.2.6. Individual Treatment Services: A set of treatment services designed to help a attain goals as prescribed an individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the individual. This service is provided by or under the supervision of a mental health professional.

3.4.3.2.2.7. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

3.4.3.2.2.8. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.

3.4.3.2.2.9. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication

compliance and positive outcomes. Individuals with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional.

3.4.3.2.2.10. Mental Health Clubhouse: A service specifically contracted by the RSN to provide a consumer directed program to individuals where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

3.4.3.2.2.10.1. Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.

3.4.3.2.2.10.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.

3.4.3.2.2.10.3. Assistance with employment opportunities; housing, transportation, education and benefits planning.

3.4.3.2.2.10.4. Operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday.

3.4.3.2.2.10.5. Opportunities for socialization activities.

3.4.3.2.2.11. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital) that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and

behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. A minimum of 8 hours of service must be provided.

3.4.3.2.2.12. Peer Support: Services provided by peer counselors to individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

3.4.3.2.2.13. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment;

and assist in treatment planning within a licensed mental health agency.

3.4.3.2.2.14. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned readmission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

3.4.3.2.2.15. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.

3.4.3.2.2.16. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake.

3.4.3.2.2.17. Supported Employment: Services will include:

3.4.3.2.2.17.1. An assessment of work history, skills, training, education, and personal career goals.

3.4.3.2.2.17.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability.

3.4.3.2.2.17.3. Preparation skills such as resume development and interview skills.

3.4.3.2.2.17.4. Involvement with consumers served in creating and revising individualized job and career development plans that include:

3.4.3.2.2.17.4.1. Consumer strengths

3.4.3.2.2.17.4.2. Consumer abilities

3.4.3.2.2.17.4.3. Consumer preferences

3.4.3.2.2.17.4.4. Consumer's desired outcomes

3.4.3.2.2.17.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.

3.4.3.2.2.17.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.

3.4.3.2.2.17.7. Services are provided by or under the supervision of a mental health professional.

3.4.3.2.2.18. Therapeutic Psychoeducation: Informational and experiential services designed to aid individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning,

community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional.

3.4.4. **State Funded Services Questions (MSR)**

3.4.4.1. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will provide Priority State Funded Services. Describe in detail how **each** service is provided including facilities, staffing, staff qualifications and sufficient narrative to illustrate the RSN's understanding of the service, understanding of the service requirements and compliance with the requirements.

3.4.4.2. Provide written policies and procedures, which have been formally adopted by the RSN, that address how the RSN will provide Additional State Funded Services. Describe in detail how **each** prioritized service is provided including facilities, staffing, staff qualifications and sufficient narrative to illustrate the RSN's understanding of the service, understanding of the service requirements and compliance with the requirements.

3.4.4.3. Provide sufficient narrative and budget detail to fully describe how the RSN is allocating and prioritizing State only funding, local funding and services. Fully explain the rational and methodology for RSN decisions.

~~3.4.4.4. Provide a written plan with a schedule describing how the RSN will have a system in place to pay community hospitals directly without using DSHS as an intermediary by September 1, 2006.~~

3.4.5. **Disaster Response Requirements**

The RSN must participate in all disaster preparedness activities and respond to emergency/disaster events (e.g., natural disasters, acts of terrorism) when requested by MHD. The RSN shall:

3.4.5.1. Attend MHD-sponsored training regarding the role of the public mental health system in disaster preparedness and response.

3.4.5.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.

3.4.5.3. Provide disaster outreach, as defined herein and as required in the State Funded Contract, for the RSN's service area in the event of a disaster/emergency.

3.4.5.4. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.

3.4.5.5. Provide the name and contact information to MHD for person(s) coordinating the RSN disaster/emergency preparedness and response upon request.

3.4.5.6. Provide information and preliminary disaster response plans to MHD within 7 days following a disaster/emergency or upon request.

3.4.5.7. Partner in disaster preparedness and response activities with MHD and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:

3.4.5.7.1. Participation when requested in local and regional disaster planning and preparedness activities.

3.4.5.7.2. Coordination of disaster outreach activities following an event.

3.4.6. **Disaster Response Questions (MR)**

3.4.6.1. Provide the name and contact information of the RSN's lead staff for Disaster Response.

3.4.6.2. Describe how the RSN will provide the services and activities outlined in the previous section.

3.4.6.3. Describe how the RSN measures and reports outcomes for the requirements.

3.4.7. **General Information Requirements**

3.4.7.1. The RSN shall provide to persons served by the RSN information on the following topics, either through the Medicaid Benefits Booklet or RSN produced materials:

3.4.7.1.1. Access to Care

3.4.7.1.2. Covered Title XIX and State Funded Services

3.4.7.1.3. Consumer/Member Service Contact Information

3.4.7.1.4. Provider Network

3.4.7.1.5. Grievance, Appeals and Fair Hearings Rights

3.4.7.1.6. Ombuds Program

3.4.7.1.7. New Initiatives

3.4.7.1.8. Consumer Rights

3.4.7.1.9. Signs of Mental Illness

3.4.7.1.10. Availability of written materials in alternative formats and how to access those formats

3.4.7.2. In addition to English, the RSN shall provide the information described above in the following prevalent languages:

3.4.7.2.1. Cambodian

3.4.7.2.2. Chinese

3.4.7.2.3. Korean

3.4.7.2.4. Laotian

3.4.7.2.5. Russian

3.4.7.2.6. Spanish

3.4.7.2.7. Vietnamese

3.4.7.3. The RSN shall:

3.4.7.3.1. Provide written materials in easily understood language and format, including alternative formats.

3.4.7.3.2. Post client rights in the languages set forth above.

3.4.7.3.3. Provide access to written interpretation of all consumer materials.

3.4.7.3.4. Provide access to these materials prior to conducting an intake evaluation.

3.4.8. **General Information Questions (MR)**

3.4.8.1. Provide written policies and procedures, which have been fully adopted by the RSN that address all the general information requirements.

3.4.8.2. Provide sufficient narrative to demonstrate the RSN's understanding of and compliance with the general information requirements.

3.4.8.3. Please provide samples of RSN produced consumer communication materials (e.g., member handbooks, member education/awareness articles/materials that reflect your ability to meet the needs of special populations including non-English speaking or the hearing impaired).

3.4.9. **For Title XIX Enrollees - Special Information Requirements**

The RSN shall provide the following written notice for Title XIX enrollees, in addition to the information requirements specified above.

3.4.9.1. Notice of provider termination. A good faith effort to inform the enrollee must be made within 15 days after the receipt or issuance of provider termination.

3.4.9.2. Notice of Action and information on grievances, appeal and fair hearing procedures and timeframes as specified in the Grievance Notice of Action.

3.4.10. **For Title XIX Enrollees - Special Information Questions (MR)**

3.4.10.1. Describe the process for notifying Title XIX enrollees of provider termination.

3.4.10.2. Describe the process and procedures for issuing a Notice of Action for Title XIX enrollees and written information provided on the grievance, appeals and fair hearing procedures and time frames.

3.4.11. **Customer Services Requirements**

The RSN shall provide Customer Services that are customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. Customer Services staff shall:

3.4.11.1. Answer customer service lines via both local and toll free numbers to respond to inquiries and complaints from 8:00 a.m. until 5:00 p.m. Monday through Friday, holidays excluded.

3.4.11.2. Answer calls within 5 rings, with an average speed of answer of 30 seconds, and a call abandonment rate of less than 3 percent.

3.4.11.3. Respond to benefits, claims, and other inquiries or complaints and assist consumers, family members and stakeholders in a manner that resolves their inquiry, including the ability to respond to those with limited English proficiency or the hearing impaired.

3.4.11.4. Log all calls and arrange for appropriate follow-up, including notification of the consumer of the resolution consistent with the requirements specified in the PIHP and the State Funded contracts.

3.4.11.5. The RSNs shall train customer services staff to distinguish between a complaint, Third Party Insurance issue, Appeals and Grievances, information requests and how to triage these to the appropriate party. Call logs shall at a minimum track date of call, type of call, and resolution.

3.4.12. **Customer Services Questions (MSR)**

3.4.12.1. Describe how customer services calls are answered during business hours. Is there an automated attendant? If yes, how many choices is the caller offered (i.e., potential buttons to press) before speaking with a staff member? Discuss how consumer services staff handle urgent and emergent calls that need to be directed to a crisis line or RSN care manager.

3.4.12.2. Discuss the required qualifications of staff providing consumer services (i.e., degree, type of experience, and years of experience).

3.4.12.3. Describe how you will handle requests from individuals with limited English proficiency and the hard of hearing.

3.4.12.4. Provide an organization chart for the customer services that includes number of staff in full-time equivalents (FTE) for each customer services staff category and primary reporting relationships.

3.4.12.5. Provide information on the expected frequency of contacts by enrollees or others, and a rationale for the RSN's staffing plan.

3.4.12.6. Describe the procedures the RSN has in place to monitor the performance of customer services staff (e.g., live call monitoring, telephone statistics, etc.).

3.4.12.7. If any of these requirements are delegated, describe the scope of the delegated function(s) or process(es); provide copies of subcontracts with the delegated entity; and address how the RSN will provide oversight of

the delegated entity. Customer Services must not be delegated to a provider of services.

3.4.12.8. Describe how the RSN measures and reports outcomes for the requirements.

3.4.13. **Eligibility Verification And Determination Requirements**

3.4.13.1. DSHS shall determine eligibility for Title XIX services and provide eligibility data to the RSN.

3.4.13.2. The RSN must have processes to verify eligibility for Title XIX and to determine eligibility for State-funded services.

3.4.13.3. The RSN must have a subcontract or agreement that outlines deliverables for any delegated functions. The RSN must demonstrate how delegated functions will be monitored.

3.4.14. **Eligibility Verification And Determination Questions (MR)**

3.4.14.1. Describe the process for verifying eligibility for Title XIX waiver services.

3.4.14.2. Describe the process for determining eligibility for State-funded mental health services.

3.4.15. **Provider Network Requirements**

3.4.15.1. The RSN shall have a provider network for both Title XIX and State funded services by service area. The network shall be based on a continuous analysis of need. The RSN shall develop an annual network management plan.

3.4.15.2. The network must be sufficient in size, scope and types of providers to offer all Title XIX and State funded program, covered mental health services required by this RFQ and fulfill all the service delivery requirements contained within the, attached PIHP and State Funded Contracts (Exhibits B and C) and State law. The RSN shall, at a minimum, consider the following factors in establishing the network:

3.4.15.2.1. Current and anticipated Title XIX eligibles.

3.4.15.2.2. Current and anticipated Title XIX mental health enrollment data.

3.4.15.2.3. Current and anticipated State funded data on eligibility and enrollment.

3.4.15.2.4. Current and anticipated utilization of services.

3.4.15.2.5. Cultural needs of mental health services recipients.

3.4.15.2.6. Number of CMHAs who are not accepting new persons.

3.4.15.2.7. Geographic location of providers, considering distance, travel time, the available transportation and whether the location provides physical access for persons with disabilities.

3.4.15.2.8. Prevalent language(s), including sign language, spoken by populations in the regional service area.

3.4.15.2.9. Quality management data, including but not limited to appointment standards data, and problem resolution.

3.4.15.2.10. Client Satisfaction Surveys.

3.4.15.2.11. Compliant, grievance and appeal data.

3.4.15.2.12. Reports of issues, concerns, or requests initiated by other State agencies that have involvement with persons covered under this RFQ.

3.4.15.2.13. Other demographic data.

3.4.15.3. The network must have a sufficient number of provider types or services to:

3.4.15.3.1. To ensure a sufficient number, mix, and geographic distribution of community mental health agencies (CMHAs) including mental health care providers (MHCPs) to meet:

3.4.15.3.1.1. An age appropriate range of mental health services for children, adolescents, adults and older adults.

3.4.15.3.1.2. A culturally competent range of services to meet the needs of special populations.

3.4.15.3.1.3. Access to medically necessary mental health services to meet the needs of the anticipated number of enrollees.

3.4.15.3.2. To ensure enrollee choice of at least two Mental Health Care Providers (MHCP) for each level of care and/or population (adult/child). An enrollee who has received authorization from the RSN for referral to a network hospital for community inpatient care

shall be allowed to choose from among all the available hospitals within the region, to the extent reasonable and appropriate.

3.4.15.4. The RSN must be available to respond to referral and authorization requests 24 hours per day, 7 days per week.

3.4.15.5. ,The RSN must provide access to treatment within the following standards:

3.4.15.5.1. Immediate/Emergent: within two hours of the request for service

3.4.15.5.2. Urgent: within 24 hours of the initial request for service

3.4.15.5.3. Intake: within 10 days of the initial request for services

3.4.15.5.4. Authorization: within 14 days of the initial request for services

3.4.15.5.5. Routine: within 14 days of authorization not to exceed 28 days from the initial request for services

3.4.15.6. The network must be geographically accessible to the service area served by the RSN and the RSN must ensure that, when enrollees must travel to service sites, they are accessible per the following standards:

3.4.15.6.1. In rural areas, service sites are within a 30-minute commute time.

3.4.15.6.2. In large rural geographical areas, service sites are accessible within a 90-minute commute time.

3.4.15.6.3. In urban areas, service sites are accessible by public transportation with the total trip including transfers, scheduled not to exceed 90 minutes each way.

3.4.15.6.4. These travel standards do not apply for psychiatric inpatient services, when the enrollee chooses to use comparable service sites that require travel beyond the travel standards, or for exceptional circumstances (e.g., inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).

3.4.15.7. The RSN must provide services, including crisis telephone services, in the person's primary or preferred language. Interpreters, whenever possible, should have training in mental health terminology to provide the person with assistance in describing the signs and symptoms of mental illness and protect the person's confidentiality.

3.4.15.8. The RSN must ensure that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.

3.4.15.9. The RSN must allow children and parents to choose to receive services from the same provider when appropriate.

3.4.15.10. The RSN must recruit consumers and family members as certified peer counselors or to provide other services.

3.4.16. **Provider Network Questions (MSR)**

3.4.16.1. Describe the needs analysis process the RSN uses to determine network adequacy for children, adolescents, adults, older adults and special populations.

3.4.16.2. Provide a copy of the RSN's network management plan, or if there is no current network plan, provide an outline of a plan. Discuss how you address the age, gender, and cultural needs of the population the RSN serves.

3.4.16.3. Indicate the unduplicated count of beds included in the RSN's network for each of the following breakouts. Include beds within the service area and outside the service area. Count each bed only once and include only those for which there are formal written agreements or that are operated by the RSN:

Types of Residential Facilities *(Do not include Mental Health Services Provided in a Residential Setting in this Table)***.**	**Number of Beds in Service Area**	**Number of Beds Outside the Service Area**
Crisis (including respite and stabilization beds)		
Long Term Psychiatric Rehabilitation (e.g. Adult Residential Rehabilitation Centers)		
Supervised Living (on site staffing 24/7, e.g. boarding homes, Adult Family Homes)		
Supported Housing (on site staffing less than 24/7, unlicensed individual or group settings)		
Other (Specify)		

Inpatient Services	**Number of Beds in Service Area**	**Number of Beds Outside the Service Area**

Community Hospital/Evaluation and Treatment Facilities		
Other (Specify)		
Total Count		

3.4.16.4. Describe the needs analysis process the RSN uses to determine network adequacy for types of residential beds and inpatient services.

3.4.16.5. Provide the following information for Clubhouses that participate in the RSN's network:

Clubhouse Name & Address	**Hours of Operation**

3.4.16.6. On average, what percentage of the above CMHAs was closed to new referrals in each of the following timeframes?

Calendar Year	Percent (%)
2003	
2004	

3.4.16.7. Please provide the RSN's percent of appointments within the following standards for calendar year 2003 and 2004.

	Requirements	**2003**	**2004**
Urgent	2 hours		
Emergent	24 hours		
Routine	Less than 28 days from request		

3.4.16.8. Provide a geo-access calculation reporting the distance of providers to consumers by zip code; as an alternative, list the number and type of provider (e.g., CMHA, hospital, clubhouse) and the number of consumers by zip code. Identify zip codes that do not meet the access standards identified in the Provider Network Requirements Section and discuss: 1) barriers to locating or contracting with providers in areas that do not meet the access standards; and (2) strategies to expand provider coverage in those areas.

3.4.16.9. Describe the RSN's approach to recruiting and tracking the availability of an adequate number of providers to deliver services, including crisis telephone services, in the person's primary or preferred language. Discuss how you monitor the availability of qualified interpreters.

3.4.16.10. Describe how you recruit consumers and family members as peer support providers or to provide other services.

3.4.16.11. Describe how the RSN ensures that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.

3.4.16.12. Describe how the RSN facilitates access to the same CMHA or provider for children and parents when appropriate.

3.4.17. **Care Management Requirements**

3.4.17.1. For the purposes of this RFQ, care management pertains to a set of clinical management oversight functions that shall be performed by the RSN. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. Resource management functions are part of care management. The goals of care management are to promote access to appropriate services; to continuously improve quality of care; and to manage resources efficiently. Care management functions are distinct from case management services and may not be delegated to a network CMHA.

3.4.17.2. The RSN shall have a psychiatric medical director (subcontracted or staff) and sufficient care managers to carry out essential care management functions including provision of:

3.4.17.2.1. The planning, coordination, and authorization of residential services and community support services, including authorization for intake evaluation.

3.4.17.2.2. The planning, coordination, and authorization for MH treatment for children eligible under the federal Title XIX Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

3.4.17.2.3. Ensure the availability of crisis plan and provider of record 7 days a week, 24 hours a day to Designated Mental Health Professionals (DMHPs), evaluation and treatment facilities, and others as determined by the RSN.

3.4.17.2.4. Authorization 24 hours a day, 7 days a week for voluntary community inpatient hospitalization. Authorizations must occur within 12 hours of the request.

3.4.17.2.5. Utilization management including review of requested services against medical necessity criteria, authorization of necessary care, and

administration of denials and appeals including access to expedited appeals.

3.4.17.2.6. Review of assessment and treatment services against clinical practice standards. Standards of practice include, but are not limited to, evidenced based practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies.

3.4.17.2.7. Risk Management, including high risk case tracking and follow-up and tracking compliance with 7- and 30-day outpatient follow-up appointments for consumers discharged from inpatient care.

3.4.18. **Care Management Questions (MSR)**

3.4.18.1. Provide a narrative description of the organization and staffing of the key care management functions listed in the previous section.

3.4.18.2. Provide an organizational chart for care management functions that includes number of staff in full time equivalents (FTE) by staff category and primary reporting relationships. Provide a rationale for the staffing plan.

3.4.18.3. Discuss the role of the psychiatric medical director, hours available to the RSN, and availability of the medical director and other psychiatrists to review inpatient care authorization/denials and complex clinical issues.

3.4.18.4. Describe the qualifications of staff performing care management functions, including staff who answers the Care Management line. Include minimum degree and years of experience requirements by staff category.

3.4.18.5. Describe the initial orientation and ongoing training protocols for care management staff.

3.4.18.6. Describe the RSN's protocols for monitoring the performance of care management staff, including live call monitoring, documentation audits, caseload reports, etc.

3.4.18.7. Describe how the RSN measures and reports outcomes for the requirements.

3.4.18.8. <u>If any of these requirements are delegated, describe the scope of the delegated function(s) or process(es); provide copies of the subcontracts</u>

with the delegated entity; and address how the RSN will provide oversight of the delegated entity.

3.4.19. **Clinical Guideline Requirements**

The RSN's care management program shall adopt and disseminate both Clinical Practice Guidelines and Level of Care Guidelines. Access to Care Standards shall be used to authorize care based on medical necessity. Level of Care Guidelines shall be used to determine continuation and discharge following an exhaustion of initial authorization period. Clinical Practice Guidelines are distinct from Level of Care Guidelines and describe treatment protocols that are evidenced-based (e.g., has a preponderance of research-based evidence demonstrating their utility in driving positive clinical outcomes). An example of a Clinical Practice Guideline would be depression treatment guidelines. The RSN's care management program shall authorize care using both Access to Care Standards and Level of Care Guidelines and, where available, Clinical Practice Guidelines that meet the following professional standards:

3.4.19.1. Levels of Care (LOC) Guidelines are based on published or peer reviewed standards. The RSN shall also incorporate the MHD's Access to Care Standards (4-07-03) in the guidelines, including the eligibility criteria for enrollee access to outpatient mental health services. Guidelines must include continuing stay and discharge criteria. The RSN must define the benefit period or length of stay and the intensity of service available for each treatment modality.

3.4.19.2. The RSN must adopted and disseminate at least two Clinical Practice Guidelines that are:

3.4.19.2.1. Based on valid and reliable research-based clinical evidence demonstrating their utility in driving positive clinical outcomes or reflecting promising practices.

3.4.19.2.2. Reflect a consensus of national mental health professionals.

3.4.19.2.3. Are adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable.

3.4.19.2.4. Are reviewed and updated biennially.

3.4.19.2.5. Are disseminated to all affected providers and, upon request, to enrollees.

3.4.19.2.6. Are applied in the administration of utilization management protocols, enrollee education and provider training.

3.4.20. **Clinical Guideline Questions (MR)**

3.4.20.1. Provide a copy of the Level of Care Guidelines.

3.4.20.2. Provide a copy of the Clinical Practice Guidelines and the source (e.g., adopted APA published guideline for depression treatment, developed internally).

3.4.20.3. For any guideline that was not adopted in full from a nationally recognized source, provide any supporting documentation to reflect that it is evidenced-based, research-based, and consensus-based or a promising practice and briefly describe the development of the Guideline.

3.4.20.4. Describe steps the RSN has taken to disseminate and apply each Clinical Practice Guideline listed above.

3.4.21. **Access Requirements**

The RSN shall:

3.4.21.1. Provide access to telephonic assessment and referral services provided by appropriately qualified care management staff via both local and toll free numbers.

3.4.21.2. Answer calls within 5 rings, with an average speed of answer of 30 seconds, and a call abandonment rate of less than 3 percent.

3.4.21.3. Arrange for access to emergent crisis services 24 hours per day, 7 days per week.

3.4.21.4. Arrange for access to urgent services within 24 hours of a request for services.

3.4.21.5. Arrange for an intake evaluation for routine services within 10 business days of a request for services.

3.4.21.6. Persons eligible for State-funded mental health services shall receive an intake evaluation based on assessment of need and available resources.

3.4.21.7. Track the Care Management access and referral line, including the volume of calls, call responsiveness statistics, and number of referrals by category of service.

3.4.21.8. Have methods to monitor compliance with access requirements, including:

3.4.21.8.1. Number of Title XIX eligible persons who request services.

3.4.21.8.2. Number of Title XIX eligible persons who receive an intake.

3.4.21.8.3. Number of persons who meet medical necessity for Title XIX services.

3.4.21.8.4. Number of Title XIX persons who meet medical necessity criteria and are referred to Title XIX or waiver services, following intake.

3.4.21.8.5. Number of persons who request State-funded mental health services.

3.4.21.8.6. Number of persons who are authorized for State-funded mental health services.

3.4.21.8.7. Length of time between the initial request and first offered appointment for an intake evaluation and length of time between the intake and first routine follow-up appointment.

3.4.21.8.8. Availability of crisis services 24 hours a day, 7 days a week, including access to Designated Mental Health Professionals for Involuntary Treatment evaluations.

3.4.22. **Access Questions (MSR)**

3.4.22.1. Describe the process for intake evaluation and referral of Title XIX persons. Provide a flow chart of the processes.

3.4.22.2. Describe the referral process for intake evaluation for State-funded mental health services. Provide a flowchart of the processes.

3.4.22.3. Does the Care Management Line have an automated attendant? If yes, how many choices is the caller offered (i.e., potential buttons to press) before speaking with a staff member?

3.4.22.4. Describe the RSN's methods for oversight of the intake process, including reports on intakes and referrals and protocols for monitoring the performance of access and referral staff (e.g., live call monitoring).

3.4.22.5. Describe how emergency calls to the RSN are handled hours and how staff transfer crisis calls to the RSN's crisis program without losing contact with the caller.

3.4.22.6. Is the RSN's clinical staff available on-site at the RSN or via pager during business hours?

3.4.22.7. Describe what clinical back-up is available to the RSN's Care Management staff (e.g., for supervisory or medical consultation).

3.4.22.8. Describe how the RSN measures and reports outcomes for the requirements.

3.4.23. **Authorization And Utilization Management Requirements**

3.4.23.1. The RSN Care Management system shall have a unified method of authorization and utilization management for title XIX and State funded Services. Authorization and utilization management shall be provided by the RSN; these functions may not be delegated. Authorization and utilization management functions may not be delegated to a network CMHA.

3.4.23.2. The RSN must have a process for the determination of medically necessary mental health services by a Mental Health Professional.

3.4.23.3. The RSN must have a process for review of treatment plan to:

3.4.23.3.1. Ensure it meets the needs of the individual.

3.4.23.3.2. Is consistent with Level of Care and applicable Clinical Practice Guidelines.

3.4.23.3.3. Includes consumer participation in the treatment planning process.

3.4.23.3.4. Involves family members, when appropriate, in the evaluations and service planning processes.

3.4.23.3.5. Includes input from other health, schools, social service, and justice agencies, as appropriate and consistent with privacy requirements.

3.4.23.4. The RSN must have a process for authorization of care following:

3.4.23.4.1. Intake assessment

3.4.23.4.2. Utilization review for continuing stay

3.4.23.5. The RSN must have a process for review by a licensed, Board-certified psychiatrist of pending denials of inpatient care prior to issuing the denial.

3.4.23.6. The RSN's policies and procedures for issuing a service denial must include:

3.4.23.6.1. Timeliness of notification.

3.4.23.6.2. Verbal and written notification.

3.4.23.6.3. Notification of appeal rights.

3.4.23.6.4. Review of all denials of all community inpatient services by a licensed, Board-certified psychiatrist.

3.4.23.7. The RSN's policies and procedures for conducting appeals must include: Physician review of all inpatient appeals and a MHP review of all other appeals.

3.4.23.8. The RSN shall have a written Utilization Management (UM) Plan that is consistent with federal requirements and which includes mechanisms to detect under utilization as well as over utilization of services.

3.4.23.8.1. UM Plan must address historical use of resources, projections of future need, and clinical management goals. Clinical management goals include the substitution of evidence based, consensus based, or promising practices, or other services that impact the use of high cost inpatient care by assisting the enrollee with recovery and symptom management.

3.4.23.8.2. The UM Plan shall have separate sections for Title XIX resources and State resources. The RSN shall actively monitor and analyze utilization and cost data for covered services by provider and program type.

3.4.23.9. The RSN shall have a routine process for comparing actual utilization to the UM Plan. The goals of this comparison are to assess how funds are utilized, to identify clinical interventions that may reduce inappropriate use of high cost services, and to track the availability of Title XIX and State resources throughout the contracts period of performance.

3.4.24. **Authorization And Utilization Management Questions (MSR)**

Provide written policies and procedures, which have been formally adopted by the RSN, addressing the determination of medically necessary mental health services and for authorizing care. At a minimum, address the following:

3.4.24.1. Which services require prior authorization.

3.4.24.2. Protocols for concurrent review ***for each level of care***. Include in the description:

3.4.24.2.1. Whether reviews are paper-based, telephonic, or utilize on-line technologies or electronic submission of required review information.

3.4.24.2.2. Type of information collected during the review process?

3.4.24.2.3. Triggers for a review (acuity, diagnosis, number of days, etc.).

3.4.24.2.4. How the RSN selects cases for outpatient concurrent review, including a description of any clinical algorithms and/or automated technologies that allow for streamlined administration of the outpatient review process.

3.4.24.3. Describe how the RSN will ensure consistent application of review criteria for authorization and continued stay decisions. At a minimum, describe the RSN's protocols for monitoring utilization management decisions to ensure inter-rater reliability across reviewers:

3.4.24.3.1. Provide copies of formal tools used for monitoring purposes.

3.4.24.3.2. Describe how cases are selected for monitoring review.

3.4.24.3.3. Indicate the frequency and volume of reviews for each Care Manager.

3.4.24.3.4. Indicate who conducts the monitoring activities, and how the monitoring team is trained to conduct these reviews.

3.4.24.3.5. Describe how feedback is summarized and provided to reviewers, including corrective actions, if indicated.

3.4.24.4. Referrals to psychiatrists or senior clinicians for review of authorization decisions for reasons other than issues of medical necessity. For example, the Care Manager may have questions about the diagnosis and relevance of the proposed treatment. Include at a minimum, the list of reasons for referral and the process for referral and completion of the consult. The process should include a description of how cases are selected for senior clinician review, information that is presented to the clinician, documentation requirements following the consult and how the RSN will ensure that recommendations are implemented during the care management process.

3.4.24.5. How consumers will be notified of the services for which they are eligible and how the RSN will facilitate the following:

3.4.24.5.1. Notification of the consumer of their determined level of care, how medical necessity was determined, and the services available within that level of care.

3.4.24.5.2. Consumer participation in decisions concerning their treatment options.

3.4.24.5.3. Consumer choice of services and providers.

3.4.24.6. Provide a copy of your most recent UM Plan describing the RSN's projected use of resources, how UM decisions are made, utilization monitoring activities, and UM reporting.

3.4.24.7. Provide copies of reports used in UM planning.

3.4.24.8. Provide sample minutes from recent meetings that reflect typical UM activities or actions.

3.4.24.9. Describe how the RSN measures and reports outcomes for the requirements.

3.4.24.10. <u>If any of these requirements are delegated, describe the scope of the delegated function(s) or process(es); provide copies of the subcontracts with the delegated entity; and address how the RSN will provide oversight of the delegated entity.</u>

3.4.25. **Grievance System - Appeals, Grievances And Fair Hearings Requirements**

The RSN shall a Grievance System, which shall include an appeals process **for Title XIX only**, a grievance process and access to the State's fair hearing process that meets standards of Washington Administrative Code (WAC) 388-865-0255 and 42 CFR 438 Subpart F, including:

3.4.25.1. A system in place that includes a grievance process, an appeal process, and access to the State's fair hearing process.

3.4.25.2. A grievance system that is used consistently through the entire service area.

3.4.25.3. Allowance for a representative of the consumer to act on their behalf in filing and pursuing complaints, grievances, and fair hearings.

3.4.25.4. Provisions for consumer access to Ombuds services to assist in addressing complaints, grievances, appeals and fair hearings.

3.4.25.5. Protocols for issuing a service denial, including requirements governing:

3.4.25.5.1. Timeliness of notification.

3.4.25.5.2. Verbal and written notification.

3.4.25.5.3. Notification of rights specific to Title XIX and State funded programs.

3.4.25.5.4. Review of all denials of inpatient services by a licensed, Board-certified psychiatrist.

3.4.25.6. A process for conducting appeals.

3.4.25.7. Qualified clinicians who can conduct appeals; minimum requirement for MHP.

3.4.25.8. Notice that a consumer or his or her representative may request a State Fair Hearing within 20 days of notice of disposition of an appeal, for Title XIX, or a grievance.

3.4.25.9. Notice that a consumer may also file a request for a Fair Hearing at any time if he/she believes there has been a violation of the Washington Administrative Code.

3.4.26. **Grievance System - Appeals, Grievances And Fair Hearings Questions (MSR)**

3.4.26.1. Provide written policies and procedures, which have been formally adopted by the RSN, and a narrative description addressing the RSN's Grievance System which includes an appeals process, for Title XIX, grievance process and fair hearing process and including:

3.4.26.1.1. The system in place that includes a grievance process, an appeal process, and access to a State Fair Hearing.

3.4.26.1.2. The grievance system that is used consistently through the entire service area.

3.4.26.1.3. Allowances for a representative of the consumer to act on his or her behalf in filing and pursuing complaints, grievances, appeals and Fair Hearings.

3.4.26.1.4. Provisions for consumer access to Ombuds services to assist in addressing complaints, grievances appeals and fair hearings.

3.4.26.2. Provide written policies and procedures, which have been formally adopted by the RSN, and a narrative description addressing the RSN's protocols for issuing a service denial, including requirements governing:

3.4.26.2.1. Timeliness of notification.

3.4.26.2.2. Verbal and written notification.

3.4.26.2.3. Notification of rights specific to Title XIX and State funded programs.

3.4.26.2.4. Review of all denials of inpatient services by a licensed, Board-certified psychiatrist.

3.4.26.3. Provide written policies and procedures, which have been formally adopted by the RSN, and a narrative description addressing the RSN's the appeals process.

3.4.26.4. Discuss the qualifications of clinicians who can conduct appeals.

3.4.26.5. Describe how the RSN provides notice that a consumer or his or her representative may request a Fair Hearing within 20 days of notice of disposition of a grievance or appeal, for Title XIX, by a RSN if the disposition is not favorable to the consumer. A consumer may also file a request for a Fair Hearing at any time if they believe there has been a violation of the Washington Administrative Code.

3.4.26.6. Describe how the RSN measures and reports outcomes for the requirements.

3.4.27. **Care Coordination Requirements**

The RSN's shall provide the following care coordination activities:

3.4.27.1. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT):** Arrange for medically necessary mental health services for children under 21 eligible for EPSDT, Medicaid's preventative health screening program for children under the age of 21. The RSN shall incorporate the following requirements into its care management, network management, and quality management activities:

3.4.27.1.1. Provide a mental health intake evaluation by a qualified children's mental health specialist.

3.4.27.1.2. Implement criteria for determining the appropriate level of medically necessary services in accord with the following levels from the Access to Care Standards:

3.4.27.1.2.1. Level I Services: Children who have a minimal need for services will be referred to Level I services or multiple agency services.

3.4.27.1.2.2. Level II Services: Children who are priority population children, in need of intensive services and involved with more than one service system, will be referred to Level II for comprehensive children's mental health services. Level II services consist of longer term intensive community-based options, integrated across all services.

3.4.27.1.3. Provide EPSDT care/resource managers to promote access to EPDST funded mental health services; to coordinate care between physicians and mental health professionals, and juvenile justice, K - 12 education child welfare staff, and foster care regarding EPSDT services; and to reduce fragmentation and duplication of efforts among child serving systems; and to control costs.

3.4.27.2. **High Risk Consumers:** Monitoring follow-up activities of the CMHA or MHCP for high risk consumers who do not appear for scheduled appointments; for individuals for whom a crisis services has been provided as the first service in order to facilitate engagement with ongoing care; and for individuals discharged from 24-hour care in order to facilitate engagement in ongoing care following discharge.

3.4.27.3. **Frequent Users of Crisis, Emergency Room and Inpatient Services:** Provide intensive care coordination for consumers who are frequent users of crisis services, the emergency room or have more than one inpatient admission within 60 days. Intensive care coordination includes, for example, increased oversight of clinical intervention strategies and/or the hospital to community transition plan.

3.4.27.4. **Primary Care and Emergency Room:** Coordination of care with each enrollee's primary care provider (PCP) and emergency rooms utilized by consumers. If the individual does not have a source of primary care, provide them assistance in accessing primary care.

3.4.27.5. **Special Populations:** Coordination of care for the following special populations as identified in WAC 388-865-0150:

3.4.27.5.1. Children

3.4.27.5.2. Older adults

3.4.27.5.3. Ethnic minorities

3.4.27.5.4. Persons with disabilities in addition to mental illness.

3.4.27.6. **Inpatient and Community Care:** Oversight of the coordination of psychiatric hospital admissions and discharges, including discharge planning that meet the following requirements:

3.4.27.6.1. Implement mechanisms that promote rapid and successful reintegration of consumers to the community from hospitals. The RSN must monitor these mechanisms for effectiveness and demonstrate how the monitoring activities are used to promote

continuity of care and quality improvement in the service delivery to hospitalized individuals.

3.4.27.6.2. Maintain an In-Residence Census (IRC) in the State Hospital facilities not to exceed the capacity funded by the legislature, and computed for the RSN by DSHS.

3.4.27.6.3. Assure contact with inpatient staff occurs within 3 working days of a voluntary or involuntary admission and participation in treatment and discharge planning with the hospital staff, includes:

3.4.27.6.3.1. Participation throughout the inpatient admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis.

3.4.27.6.3.2. Coordination with hospital staff to develop appropriate community placement and treatment service plans.

3.4.27.6.3.3. Designation of a CMHA that has the primary responsibility to coordinate outpatient and residential services to be provided to the individual based on medical necessity and available resources. The assigned CMHA must offer, at minimum, one follow-up service within 7 days from discharge and one follow-up service within 30 days of discharge.

3.4.27.6.4. Monitor for effectiveness of the above activities and demonstrate how the monitoring is used to promote continuity of care and quality improvement in the service delivery to hospitalized individuals.

3.4.27.6.5. Respond to State hospital census alert notifications by using best efforts to divert State psychiatric hospital admissions and expediting discharges from the State psychiatric hospital using alternative community resources and mental health services.

3.4.27.6.6. The RSN must respond to requests for monitoring, authorization, coordination and ensuring provision of medically necessary mental health outpatient services to individuals who are:

3.4.27.6.6.1. On a Less Restrictive Alternative court order in accordance with RCW 71.05.320

3.4.27.6.6.2. On a Conditional Release under RCW 71.05.340

3.4.27.6.6.3. On a Conditional Release under RCW 10.77.150

3.4.27.6.7. Care management/resource management for the Children's Long-term Psychiatric Inpatient Programs (CLIP): Provide care/resource management of children served by CLIP that are specified in a written agreement between the RSN and the CLIP Administration.

3.4.28. **Care Coordination Questions (MSR)**

3.4.28.1. Describe the RSN's approach and provide written policies and procedures, which have been formally adopted by the RSN, that address each item and all requirements in the care coordination requirements in the previous section:

3.4.28.1.1. EPSDT

3.4.28.1.2. High Risk Consumers

3.4.28.1.3. Frequent Users of Crisis, Emergency Room and Inpatient Services

3.4.28.1.4. Primary Care and Emergency Room

3.4.28.1.5. Special Populations

3.4.28.1.6. Inpatient and Community Care

3.4.28.2. Describe how the RSN measures and reports outcomes for the requirements.

3.4.29. **Quality Assurance/Performance Improvement Program Requirements**

3.4.29.1. The RSN shall have qualified and sufficient staff to support the quality management/performance improvement (QA/PI) activities identified in this section.

3.4.29.2. The RSN shall have one written, integrated Quality Assurance/Performance Improvement Program (QA/PI) that addresses Title XIX and State funded programs.

3.4.29.2.1. The QA/PI program shall have a system to collect data, conduct monitoring, verify services and review its ongoing quality management program to monitor the assessment of, and improvements to, the quality of public mental health services in their service area and to determine the effectiveness of the overall regional system of care.

3.4.29.2.2. For Title XIX services, the RSN shall establish and maintain a written program for a QA/PI consistent with federal 42 CFR 434.34 and 42 CFR 438.240 and with the utilization control program as described in 42 CFR 456.

3.4.29.2.3. For State-funded services, the RSN shall establish and maintain a written program for QA/PI. These documents shall comprise the QA/PI Plan.

3.4.29.3. The RSN shall meet or exceed MHD, defined minimum performance levels on standardized performance indicators listed below:

3.4.29.3.1. Medicaid Penetration Rate of 10%.

3.4.29.3.2. Time from the initiation of an intake evaluation to first non-crisis appointment shall not exceed 14 days.

3.4.29.3.3. State Hospital Bed Utilization shall not exceed the RSN allocation.

3.4.29.3.4. Outpatient Services must be provided within 7 days following a hospital discharge.

3.4.29.3.5. Telesage Outcome Assessment initiated at time of intake.

3.4.29.4. Describe how the RSN will incorporate the analysis of performance indicator results into quality improvement activities.

3.4.29.5. Develop and implement four performance improvement projects two clinical and two non-clinical using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and enrollee satisfaction.

3.4.29.6. Have in effect mechanisms to assess the quality and appropriateness of care furnished to enrollees with mental health care needs.

3.4.29.7. Include all demographic groups, care settings, and types of services in the scope of the review occurring over multiple review periods.

3.4.29.8. Measure provider performance through medical record audits.

3.4.29.9. Provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the RSN.

3.4.29.10. Participate in an External Quality Review authorized by DSHS.

3.4.29.11. The RSN shall maintain an active QA/PI committee that coordinates with the RSN Quality Review Teams described in WAC 388-865-0282, which shall be responsible for carrying out the planned activities of the QM/PI

program. This committee shall have regular meetings, shall document participation by providers, and shall be accountable and report regularly to the governing board. The RSN shall maintain records documenting the committee's findings, recommendations, and actions. The committee shall address both Title XIX and State funded services. At a minimum, the RSN's psychiatric medical director shall consult to the QA/PI committee and assist with setting QA/PI goals.

3.4.29.12. The RSN shall designate a senior executive who shall be responsible for program implementation. The RSN's must ensure that a qualified Mental Health Professional shall have substantial involvement in the QA/PI program functions.

3.4.29.13. The QA/PI program shall integrate the results of activities such as, but not limited to, consumer satisfaction surveys; performance improvement projects (PIP); external quality reviews (EQR); and grievance and appeals data.

3.4.30. **Quality Assurance/Performance Improvement Program Questions (MSR)**

3.4.30.1. Describe the organization and staffing of the RSN's Quality Assurance/Performance Improvement ("QA/PI") Program. Provide the number and qualifications of staff administering the QA/PI program and rationale for this staffing and qualifications.

3.4.30.2. Provide a copy of your most recent QA/PI plan.

3.4.30.3. Provide a copy of your QA/PI plan that includes performance metrics monitored in the last 12 calendar months. Include the metric, targeted performance or goal, and actual performance against goal.

3.4.30.4. Describe the composition of the QA/PI Committee. Identify who chairs the committee and identify committee members by type of position (consumer representative, provider representative, etc.). Discuss the role of the psychiatric medical director and the Quality Review Team with the QA/PI Committee.

3.4.30.5. Describe how frequently the QA/PI committee meets.

3.4.30.6. Provide copies of sample reports reviewed by the QA/PI Committee.

3.4.30.7. Provide sample minutes from recent QA/PI committee meetings that reflect the typical activities or actions by the committee.

3.4.30.8. ~~Provide one examples each of how the RSN implemented a quality improvement initiative for Title XIX enrollees and for consumers~~

~~receiving State-funded services resulting from QA/PI activities in FY 2005.~~ Provide two examples of how the RSN implemented quality improvement initiatives resulting from QA/PI activities prior to September 1, 2005.

3.4.30.9. Describe the process for integrating consumer satisfaction survey data into the QA/PI program.

3.4.30.10. Describe how the RSN monitors clinical outcomes and utilizes results of to measure program effectiveness. ~~, in the care management program to measure clinical progress in treatment at the individual level~~

3.4.30.11. Describe how you monitor provider performance, including the following items:

3.4.30.11.1. The RSN's protocol for conducting site visits of providers, including medical record reviews.

3.4.30.11.2. The RSN's protocol for profiling provider performance on cost, access, and quality, including what is measured and how results are used to provide feedback to providers on their performance.

3.4.30.11.3. Include a copy of a sample provider profiling report, if available.

3.4.30.11.4. Other methods for training or monitoring provider performance, including compliance with Clinical Practice Guidelines.

3.4.30.12. Describe how the RSN shall meet or exceed MHD defined minimum performance levels on standardized performance indicators listed below:

3.4.30.12.1. Medicaid Penetration Rate of 10%.

3.4.30.12.2. Time from the initiation of an intake evaluation to first non-crisis appointment shall not exceed 14 days.

3.4.30.12.3. State Hospital Bed Utilization shall not exceed the RSN allocation.

3.4.30.12.4. Outpatient Services must be provided within 7 days following a hospital discharge.

3.4.30.12.5. Telesage Outcome Assessment initiated at time of intake.

3.4.30.13. Describe how the RSN will incorporate the analysis of performance indicator results into quality improvement activities.

3.5. **Tribal Authority Relationships**

3.5.1. **Tribal Authority Relationships Requirements**

3.5.1.1. The RSN and it's subcontractors must recognize the unique political and legal status of Indian nations as required by the Supremacy and the Indian Commerce clauses of the United States Constitution; federal treaties; executive orders; Indian Citizen Act of 1924 statutes; and State and federal court decisions, or any Memorandum of Agreement or Understanding, signed by the State of Washington and a federally recognized tribe, and reflective of the Centennial Accord between the Washington State government and recognized Washington Tribes.

3.5.1.2. The RSN must inform tribal governments of their right to be represented as a party to the Regional Support Network and of opportunities to collaborate with the RSN to provide culturally competent services to Tribal members.

3.5.1.3. The RSN shall develop a RSN/Tribal Plan in collaboration with each Indian Nation within the RSN's service area that addresses:

3.5.1.3.1. Coordination and collaboration with the tribe regarding Title XIX and State funded mental health services for Tribal members including the following.

3.5.1.3.2. Coordination and collaboration with RSNs and tribes when tribal boundaries cross RSN boundaries.

3.5.1.3.3. Identification of a contact person(s) and/or process within the RSN to assist in integration of agreements with the tribes.

3.5.1.3.4. The reduction of duplicative screening and evaluation processes and ongoing coordination of care between the Tribes and RSN for Tribal members receiving their primary outpatient mental health care from a tribal provider, and who may need or be receiving Title XIX or State funded mental health services through an RSN authorized provider.

3.5.1.4. The RSN must develop working protocols and procedures with Tribal facilities and/or Tribal providers, upon request by a Tribe, to address the following:

3.5.1.4.1. Provision of Title XIX services to Tribal members who are Title XIX enrollees and who choose to receive mental health services through an RSN provider.

3.5.1.4.2. Provision of non-Medicaid services, including crisis services and involuntary treatment services as defined in RCW 71.05 and RCW 71.34 to Tribal members.

3.5.1.4.3. Provision of Mental Health Specialist consultations as required in WAC 388-864-0425.

3.5.2. **Tribal Authority Relationships Questions (MSR)**

3.5.2.1. Describe how the RSN and its subcontractors meet the requirement to recognize the unique political and legal status of Indian nations.

3.5.2.2. Describe how the RSN informs tribal governments of their right to be represented as a party to the Regional Support Network and of opportunities to collaborate with the RSN to provide culturally competent services to Tribal members.

3.5.2.3. Describe the key elements of your current plan and protocols regarding collaboration and agreements with Tribal nations within your RSN area that address the requirements. If your current protocols are not compliant with the requirements, describe your plan and schedule for having compliant protocols in place by September 1, 2006. Provide documentation if the tribal authority declines to participate.

3.5.2.4. Describe your current and future procedures for developing working protocols and procedures with Tribal Facilities and/or providers.

3.5.2.5. Describe how the RSN measures and reports outcomes for the requirements.

3.6 Community Hospital Inpatient Responsibility Requirement and Question (MR)

It is DSHS' intention, at some point in the future, to transfer the responsibility for payment for community hospital inpatient services to RSNs. Assume that the DSHS Numbered Memorandum 01-03 MAA will be modified or rescinded to implement the change. Describe issues and processes that need be addressed prior to implementation of this change.

EXHIBIT A
RSN INFORMATION, CERTIFICATIONS AND ASSURANCES FORM
STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
CENTRAL CONTRACT SERVICES
Request for Qualifications (RFQ) # 0534-187

Completion of this RSN Information form is a mandatory requirement for contracting with the Washington Department of Social and Health Services (DSHS). The certifications and assurances contained herein are a required element of the response.

Failure to submit this RSN Information form or any applicable attachments with your response may result in your response being rejected as non-responsive.

Please Type or Print Legibly:

RSN Name:			
RSN Address:			
Telephone:		Fax Number:	
Contact Person for the RSN's response:			

Check the applicable box and complete the sections identified.

Provide additional information on separate sheets as may be required in each section

Section A:

1. The RSN's Federal Identification number is: _____

2. The RSN's Washington Uniform Business Identifier (UBI) Number is: _____
   To obtain a Washington UBI Number call 360-664-1400.

3. Information concerning the proposed Contract Manager for the RSN:

Name:				
Work Address:				
Telephone:			Fax Number:	

4. Has the RSN had a contract or work order terminated for default during the last five years?

   ☐ Yes ☐ No

   If yes, attach a signed statement describing the contract, the circumstances surrounding the termination, and the name, address and telephone number of the other party to the contract. DSHS will evaluate the facts and may, at its sole discretion, reject the RSN's response on the ground of its past performance. For the purpose of this question, "termination for default" means notice was given to the RSN to stop contract work due to nonperformance or poor performance, and the performance issue was either (a) not contested by the RSN or (b) litigated, finding the RSN in default.

5. The RSN declares that all answers and statements made in the response are true and correct.

6. The RSN's response is a firm offer for a period of 365 days following receipt, and it may be accepted by DSHS without further negotiation (except where obviously required by lack of certainty in key terms) at any time within the 365-day period. In the case of a protest, the RSN's response will remain valid for 365 days or until the protest is resolved, whichever is later.

7. In preparing this Response, the RSN and/or the RSN's employees have not been assisted by any current or former DSHS employee whose duties relate (or did relate) to this procurement and who was assisting in other than his or her official, public capacity.

8. The RSN acknowledges that DSHS will not reimburse the RSN for any costs incurred in the preparation of this response. All responses become the property of DSHS, and the RSN claims no proprietary right to the ideas, writings, items or samples.

9. The RSN acknowledges that any contracts awarded as a result of this procurement will be modeled after the PIHP and State Funded Contracts included with this RFQ. I certify, on behalf of the RSN, that the RSN will comply with these or substantially similar PIHP and State Funded Contracts if selected as an Apparently Successful RSN.

10. The RSN understands that, if selected to contract with DSHS, the RSN will be required to comply with all applicable State and federal civil rights and other laws. Failure to so comply may result in contract termination. If requested by DSHS, the RSN agrees to submit additional information about the nondiscrimination policies of the RSN's organization in advance of or after the contract award.

11. The RSN' certifies that is has a current Washington Business License, and agrees to promptly provide a copy of the license in the event the RSN is selected as the Apparently Successful RSN.

12. If there are any exceptions to these assurances or RSN has been assisted, identify on a separate page attached to this document each such individual by (a) name, (b) current address and telephone number, (c) current or former position with DSHS, and (d) dates of employment with DSHS; and describe in detail the assistance rendered by that individual.

Section B:

1. The RSN is a public agency as defined in Section 39.34.020 RCW and is a:

☐ State Agency	☐ Institution of Higher Learning
☐ County	☐ Public School
☐ City	☐ Federally Recognized Tribe
☐ Other:	

2. Is any Manager or Employee of the RSN a past or current State of Washington employee?

   ☐ Yes ☐ No If yes, list names, positions, and dates of employment with the State of Washington in an attachment to this form.

3. Is any employee of the RSN who will perform work under a contract between the RSN and DSHS a past or current State of Washington employee?

☐ Yes ☐ No If yes, list names, positions, and dates of employment with the State of Washington in an attachment to this form.

4. I am authorized to bind the RSN to a contract or the name and title of the individual who is authorized to bind the RSN to a contract and who will be signing any contracts between DSHS and the RSN is:

Name:	
Title:	

Section C:

1. By signing below, the RSN authorizes DSHS to conduct a financial assessment and/or background check of the RSN if DSHS considers such action necessary or advisable before contracting with the RSN.

2. Under the penalties of perjury of the State of Washington, the undersigned affirms the truthfulness of the statements made herein. The undersigned certifies that the RSN is now, and shall remain, in compliance with the certifications and assurances contained herein, and agrees that such compliance is a condition precedent to the award and continuation of any related contracts. The undersigned acknowledges the RSN's obligation to notify DSHS of any changes in the statements, certifications and assurances made herein.

Signature		Date
Printed or Typed Name		
Title		

EXHIBIT D
CHECKLIST FOR RESPONSIVENESS

- ☐ Response was submitted on or before 3:00 p.m. on the due date.
- ☐ Required numbers of copies were submitted.
- ☐ Response is placed in binders with tabs separating the major sections of the response. The five major sections shall include:
  - ☐ 3.1 Special Initiatives
  - ☐ 3.2 Administrative and Financial Requirements
  - ☐ 3.3 Information System Requirements
  - ☐ 3.4 RSN Program Requirements
  - ☐ 3.5 Tribal Authority Relationships
- ☐ Response is placed in binders with tabs separating the major sections of the response.
- ☐ RSN is currently operating
- ☐ Response is complete, i.e. the RSN responded to all requirements.
- ☐ The response does not impose conditions that would modify the RFQ.
- ☐ Letter of Submittal and Certifications and Assurances were signed by an individual authorized to bind the RSN to a contractual relationship.